Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection against the *National Standards for Safer Better Healthcare*.

Name of healthcare service provider:	University Hospital Limerick
Address of healthcare service:	St Nessan's Rd Dooradoyle Co. Limerick V94 F858
Type of inspection:	Unannounced
Date of inspection:	21 and 22 February 2023
Healthcare Service ID:	OSV-0001064
Fieldwork ID:	NS_0027

About the healthcare service

The following information describes the services the hospital provides.

Model of Hospital and Profile

University Hospital Limerick (UHL) is a Model 4* acute teaching hospital managed by the University Limerick Hospitals Group (ULHG)† on behalf of the Health Service Executive (HSE). The six hospital sites in the ULHG are described as functioning as a single hospital system using a hub-and-spoke model, where critical care facilities are centralised at UHL supported by Model 2‡ and Model 2S (specialised) hospitals in the hospital group. Unlike the structure of other hospital groups in Ireland,§ there is no Model 3** hospital in ULHG. A range of healthcare services are provided across the six hospital sites under the leadership of five clinical directorates — cancer service directorate; medicine directorate; peri-operative directorate; diagnostics directorate and maternal and child health directorate. A sixth directorate — operational services is concerned with the effective operational functioning of all hospital sites in ULHG.

UHL provides the following services to the population of around 400,000 in the Midwest region of Ireland on an inpatient and outpatient basis:

- major elective surgery
- cancer treatment and care
- emergency care
- high-dependency care
- a range of other medical inpatient services, diagnostic and therapy services
- outpatient care.

The following information outlines some additional data on the hospital.

Model of Hospital	4
Number of beds	530 inpatient beds 149 day case beds

* A Model 4 hospital is a tertiary hospital that provides tertiary care and, in certain locations, supra-regional care. The hospital has a category 3 or speciality level 3(s) Intensive Care Unit onsite, a Medical Assessment Unit which is open on a continuous basis (24 hours, every day of the year) and an Emergency Department, including a Clinical Decision Unit onsite.
† The University Limerick Hospitals Group (ULHG) comprises six hospitals - University Hospital Limerick, University Maternity Hospital Limerick, Nenagh Hospital, Ennis Hospital, Croom Orthopaedic Hospital and St. John's Hospital. The hospital group's academic partner is the University of Limerick.
‡ A Model 2 hospital provides in-patient and out-patient care for differentiated, low-risk medical patients, who are not likely to require full resuscitation.
§ The other hospital groups are the Dublin Midlands Hospital Group, South/South West Hospital Group, Saolta University Health Care Group, Ireland East Hospital Group and Royal College of Surgeons in Ireland (RCSI) Hospitals Group.
** A Model 3 hospital admits undifferentiated acute medical patients, provides 24/7 acute surgery, acute medicine and critical care.

How we inspect

Under the Health Act 2007, Section 8(1) (c) confers the Health Information and Quality Authority (HIQA) with statutory responsibility for monitoring the quality and safety of healthcare services among other functions. This two-day unannounced inspection at UHL was carried out to assess compliance with the *National Standards for Safer Better Healthcare* as part of HIQA's role to set and monitor standards in relation to the quality and safety of healthcare services. The inspection was a follow-on to HIQA's inspection of UHL's emergency department in March 2022. The purpose of this inspection was to assess:

- compliance with 11 national standards from the *National Standards for Safer Better Healthcare*
- the effectiveness of measures implemented to address the issue of overcrowding in the emergency department, insufficient inpatient bed capacity and patient flow through the hospital and wider hospital group identified during HIQA's last inspection in March 2022.

To prepare for this inspection, inspectors[††] reviewed relevant information about UHL. This included any previous inspection findings, information submitted by UHL and ULHG, unsolicited information[‡‡] and other publically available information.

As part of the inspection, HIQA inspectors:

- spoke with people who used the healthcare services in UHL to ascertain their experiences of the service
- spoke with staff and management to find out how they planned, delivered and monitored the service provided to people who received care and treatment in UHL
- observed care being delivered, interactions with people who used the service and other activities to see if it reflected what people told inspectors
- reviewed documents to see if appropriate records were kept and that they reflected practice observed and what people told inspectors during the inspection.

A summary of the findings and a description of how UHL performed in relation to the national standards assessed during the inspection are presented in the following sections, under the two dimensions of capacity and capability and quality and safety.

[††] Inspector refers to an authorised person appointed under the Health Act 2007 for the purpose of monitoring compliance with the *National Standards for Safer Better Healthcare.*
[‡‡] Unsolicited information is defined as information, which is not requested by HIQA, but is received from people including the public and or people who use healthcare services.

Findings are based on information provided to inspectors at a particular point in time — before, during and following the on-site inspection at UHL.

1. Capacity and capability of the service

This section describes HIQA's evaluation of how effective the governance, leadership and management arrangements are in supporting and ensuring that a good quality and safe service is being sustainably provided in UHL. It outlines whether there is appropriate oversight and assurance arrangements in place at UHL and how people who work in the service are managed and supported to ensure high-quality and safe delivery of care.

2. Quality and safety of the service

This section describes the experiences, care and support people using the service receive on a day-to-day basis. It is a check on whether the service is a good quality and caring one that is both person centred and safe. It also includes information about the healthcare environment where people receive care.

A full list of the 11 national standards assessed as part of this inspection and the resulting compliance judgments are set out in Appendix 1.

Compliance classifications

Following a review of the evidence gathered during the inspection, a judgment of compliance on how UHL performed has been made under each national standard assessed. The judgments are included in this inspection report. HIQA judges the healthcare service to be **compliant, substantially compliant, partially compliant** or **non-compliant** with national standards. These are defined as follows:

Compliant: A judgment of compliant means that on the basis of this inspection, the service is in compliance with the relevant national standard.
Substantially compliant: A judgment of substantially compliant means that on the basis of this inspection, the service met most of the requirements of the relevant national standard, but some action is required to be fully compliant.
Partially compliant: A judgment of partially compliant means that on the basis of this inspection, the service met some of the requirements of the relevant national standard while other requirements were not met. These deficiencies, while not currently presenting significant risks, may present moderate risks, which could lead to significant risks for people using the service over time if not addressed.

Non-compliant: A judgment of non-compliant means that this inspection of the service has identified one or more findings, which indicate that the relevant national standard has not been met, and that this deficiency is such that it represents a significant risk to people using the service.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
21 February 2023	09:00 to 18:00hrs	Denise Lawler	Lead
		John Tuffy	Support
22 February 2023	09.00 to 14.30hrs	Nora O Mahony	Support
		Danielle Bracken	Support

Background to this inspection

This unannounced inspection of UHL was carried out as part of HIQA's statutory role to monitor the quality and safety of healthcare services and as a follow-on to HIQA's inspection of UHL's emergency department in March 2022. UHL has the only emergency department in the Midwest region of Ireland providing undifferentiated care[§§] for adults and children with acute and an urgent illness or injuries 24/7. The Midwest region also has three local injury units located in St John's Hospital, Ennis Hospital and Nenagh Hospital that provides treatment for people with minor injuries who are unlikely to need admission to hospital.

Over the past number of years, overcrowding has been a persistent challenge for the majority of the 29 emergency departments across the country, but especially so for UHL. UHL's emergency department has experienced unprecedented levels of attendance since January 2022. The hospital has one of the highest rates of attendance year on year. The recorded attendances to UHL's emergency department in 2022 was 79,644, which was the second highest level of attendances of all the Model 4 hospitals in the country that year. Furthermore, the occupancy rate of inpatient beds at UHL in 2022 was 105%. This occupancy rate has become the operational norm at UHL and is well above the maximum operating occupancy rate of 85% proposed by the Department of Health in the capacity review report of 2018.

On 15 March 2022, HIQA carried out a risk-based unannounced inspection of UHL's emergency department to determine the hospital's level of compliance with four national standards (5.5, 6.1, 1.6 and 3.1) from the *National Standards for Safer Better Healthcare*. In particular, the inspection assessed the contingency measures in place to mitigate the impact of overcrowding in the emergency department over the imminent four-day long weekend of March 2022. At the time, HIQA found significant non-compliance with the four national

[§§] Undifferentiated care: care provided to patients presenting to the emergency department with defined but various symptoms that do not fit into a defined diagnostic pattern.

standards assessed and inspectors were not assured that the measures implemented by hospital management were adequate and sufficiently effective in managing the overcrowding of the emergency department and the risks to patient safety identified during that inspection. HIQA acknowledged that risk issues identified at that time needed to be sustainably addressed in the short-term, but also noted that it was of critical importance that a formally agreed and fully funded longer term plan for the Midwest region, aligned with the principles outlined through Sláintecare be implemented. Following HIQA's inspection, hospital management at UHL submitted a compliance plan to HIQA, which set out the short, medium and long-term actions to be implemented in order to bring UHL into compliance with the four national standards from the *National Standards for Safer Better Healthcare* assessed in March 2022.

The association between an increase in morbidity and mortality and overcrowding in emergency departments is well established. Hospital management and the HSE recognise and acknowledge that a key causal factor of overcrowding of UHL's emergency department is UHL's inpatient bed capacity, which is insufficient to meet the growing demand in the Midwest region. At the time of this inspection, a 96-bed building project was underway to increase extra inpatient capacity at UHL by the end of 2024. However, under current plans, 50% of the extra inpatient capacity gained from this build will be replacement beds that will be used to bring UHL into compliance with best practice standards in infection prevention and control. Therefore, any anticipated gains in increased inpatient capacity at UHL may be limited when that new build comes online in 2024. Consequently, the issue of constrained capacity at UHL will remain in the short and medium-term. During this time, it is necessary that hospital management mitigate the well established risks to patient safety associated with the overcrowding of the emergency department and the wider implications arising from this on the other healthcare services provided at UHL.

Following HIQA's inspection in March 2022, the HSE convened a support team comprising representatives from the HSE's National Acute Operations, Special Delivery Unit, National Community Operations including Primary Care Operations, Older Persons Operations and Performance and Integration Unit to support hospital management to identify and achieve sustainable operational effectiveness and efficiencies across UHL. In keeping with HIQA's previous inspection findings, the support team identified the need for urgent action at UHL and set out 20 recommendations to be implemented across the following five areas:

- leadership, culture and governance
- patient flow pre admission
- patient flow post admission
- integrated community and hospital services
- use of information to measure and monitor performance improvement.

The support team were onsite at UHL for a four week period between May and June 2022 and also throughout July 2022 to support hospital management and clinical staff to improve operational and clinical efficiencies across the hospital. ULHG and UHL also received

significant support and financial resourcing (approximately €6m per annum) to improve operational and clinical effectiveness and efficiencies at UHL and across ULHG, and to further strengthen and enhance integration with the Midwest Community Healthcare Organisation (MWCH). These supports are discussed in further detail under national standard 5.5.

In early January 2023, a record increase in the number of attendees to UHL's emergency department resulted in the executive management declaring a major incident at the hospital. At that time, a number of measures was introduced to manage the incident, including increasing availability and accessibility to community services over seven days (7/7) for a three week period. In addition, a change in approach was introduced whereby a small number of non-urgent 112/999 patients were directly conveyed to the Acute Medical Assessment Unit in Ennis Hospital as part of a formally agreed new protocol with the National Ambulance Service (NAS). The latter measure remains in place at the time of writing this inspection report.

On the 21 and 22 February 2023, HIQA carried out an unannounced inspection at UHL to assess:

- compliance with 11 national standards from the *National Standards for Safer Better Healthcare*
- the progress in implementing the short and medium-term actions set out in the compliance plan that hospital management submitted to HIQA
- the effectiveness of initiatives implemented as a result of enhanced supports and resourcing to improve operational and clinical efficiencies at UHL.

This inspection also focused on the following four key areas of known harm:

- infection prevention and control
- medication safety
- the deteriorating patient[***] (including sepsis)[†††]
- transitions of care.[‡‡‡]

During the inspection, the inspection team visited the following clinical areas:

- Emergency department
- Trauma Ward (peri-operative ward)
- 3A Ward (medical ward)
- 3D Ward (step-down cardiology ward)

[***] The National Deteriorating Patient Improvement Programme (DPIP) is a priority patient safety programme for the Health Service Executive. Using Early Warning Systems in clinical practice improve recognition and response to signs of patient deterioration. A number of Early Warning Systems, designed to address individual patient needs, are in use in public acute hospitals across Ireland.
[†††] Sepsis is the body's extreme response to an infection. It is a life-threatening medical emergency.
[‡‡‡] Transitions of care include internal transfers, external transfers, patient discharge, shift and interdepartmental handover. World Health Organization. *Transitions of Care. Technical Series on Safer Primary Care*. Geneva: World Health Organization. 2016. Available on line from https://apps.who.int/iris/bitstream/handle/10665/252272/9789241511599-eng.pdf.

- Acute Medical Unit
- Acute Surgical Assessment Unit
- Rapid Access Medical Unit.

On the days of inspection, the inspection team also spoke with the following staff from UHL and ULHG:

- Representatives of the ULHG's Executive Management Team:
    - Chief Executive Officer
    - Chief Clinical Director
    - Chief Operations Officer
    - Director of Human Resources
- Head of Operational Services, UHL
- Director of Quality and Patient Safety, ULHG
- Complaints Manager, UHL
- Discharge Coordinator/Bed Manager, UHL
- Clinical Directors from each of the six clinical directorates, ULHG
- Assistant Director of Nursing for the medicine directorate, ULHG
- Assistant Director of Nursing for the maternal and child health directorate, ULHG
- Lead representatives for non-consultant hospital doctors (NCHDs)
- Representatives from each of the following UHL and ULHG committees:
    - Infection Prevention and Control Committee
    - Medication Safety and Drug and Therapeutics Committee
    - Deteriorating Patient Steering Committee.

Following the inspection, inspectors also met with the Chief Officer and representatives from the regional HSE Community Health Organisation, and representatives from the out of hours general practitioner (GP) services in Limerick to better understand the factors in the Midwest region that were affecting overcrowding in UHL's emergency department. Inspectors also met with the HSE's National Director for Acute Operations and members of the HSE's support team to further support HIQA's findings through the inspection process.

Acknowledgements

HIQA would like to acknowledge the cooperation of the management team and staff who facilitated and contributed to this inspection. In addition, HIQA would also like to thank people using the service who spoke with inspectors about their experience of receiving care in UHL.

What people who use the service told inspectors and what inspectors observed in the clinical areas visited

During this inspection, inspectors visited the emergency department, three inpatient clinical areas, the Acute Medical Unit (AMU), Acute Surgical Assessment Unit (ASAU) and Rapid Access Medical Unit (RAMU).

Emergency department

UHL's emergency department comprised four triage rooms (three for adults and one for paediatrics) and 49 single treatment cubicles set out in four zones, which included a clinical decision unit. The department also comprised a dedicated paediatric area with audiovisual separation from the adult emergency department area as recommended in the HSE's National Emergency Medicine Programme.[§§§] A new dedicated assessment area — Geriatric Emergency Medicine Unit (GEMU), was established since HIQA's last inspection and became operational in October 2022. This unit had a defined eligibility criteria and had a dedicated team of health and social care professionals and NCHDs, who assessed and treated people aged 75 years and over that presented to UHL's emergency department. The initiative was aimed at avoiding hospital admission for this cohort of patients in a setting within the emergency department that was more appropriate to their specific needs, with appropriate follow on referral to and delivery of care by community services such as the HSE's Integrated Care Programme for Older Persons (ICPOP) and OPTIMEND.[****]

Patients presented to UHL's emergency department by ambulance, were referred by their GP or self-referred. Almost half (48%) of the patients who attended the emergency department on the first day of this inspection were self-referred, which was similar to the number of self-referrals in March 2022. In 2022, 76% of attendees to the emergency department completed their episode of care in the department and 24% of patients were admitted to an inpatient bed. On the first day of this inspection, inspectors found the emergency department was grossly overcrowded with a total of 121 patients registered in the department at 11.00am. Documentation reviewed by inspectors showed that a total of 246 people attended UHL's emergency department that day, marginally lower that the daily attendance of 290 people in March 2022.

Inpatient clinical areas visited on inspection

Trauma Ward was a large 29-bedded ward comprising three, two-bedded multi-occupancy rooms, a six-bedded multi-occupancy room, a large 14-bedded multi-occupancy room

[§§§] The National Emergency Medicine Programme, a strategy to improve safety, quality, access and value in Emergency Medicine in Ireland: June 2012.
[****] The OPTIMEND service provides multidisciplinary assessment and intervention to the 75 years and older patient cohort attending the emergency department.

('nightingale ward')[††††] and three single rooms with ensuite bathroom facilities. The ward accommodated male and female perioperative patients. At the time of this inspection, all 29 beds were occupied and there was one additional patient accommodated on a trolley on the corridor. The clinical area had adequate communal toilet and bathroom facilities for patient use.

3A Ward was a large 26-bedded ward comprising two, two-bedded multi-occupancy rooms, two, four-bedded multi-occupancy rooms, a large eight-bedded multi-occupancy room and six single rooms with ensuite bathroom facilities. The ward accommodated male and female medical patients. At the time of this inspection, two beds were closed and the remaining 23 beds were occupied. There were also three additional patients accommodated on trolleys — one patient was accommodated in a closed bed space, another on the corridor and the third patient on a trolley in the large eight-bedded multi-occupancy room. The clinical area had adequate communal toilet and bathroom facilities for patient use.

3D Ward was a large 31-bedded ward comprising two, two-bedded multi-occupancy rooms, one, four-bedded multi-occupancy rooms, a five-bedded multi-occupancy room, a large 12-bedded multi-occupancy room (nightingale ward) and five single rooms with ensuite bathroom facilities. The ward accommodated male and female cardiology and general medical patients. At the time of this inspection, 30 beds were occupied and there were two additional patients accommodated on trolleys on the corridor. The clinical area had adequate communal toilet and bathroom facilities for patient use.

The AMU operated 24/7 and had a planned capacity of 25, comprising 13 beds, six trolleys and six seats. At the time of this inspection, the AMU was fully occupied with three additional trolleys located on the corridor. Fourteen (50%) of the 28 patients were admitted patients boarding in the unit while awaiting an inpatient bed in the main hospital. The RAMU was an admission avoidance unit, which had a pathway for deep venous thrombosis (DVT)[‡‡‡‡] delivered by clinical nurse specialists (CNS).[§§§§]

The ASAU operated 24/7 and had a planned capacity of 25. At the time of this inspection, 23 patients were in the ASAU, with six (26%) of these patients boarding in the unit while awaiting an inpatient bed in the main hospital. In essence, inspectors found that the AMU and ASAU were not functioning as should be, as an alternate flow pathway for patients. Similar to HIQA's findings in March 2022, this indicated to inspectors that the normal means

[††††] Nightingale ward is of one large room without subdivisions, comprising a large number of beds arranged along the sides of the room.
[‡‡‡‡] Deep vein thrombosis (DVT) is a blood clot that develops within a deep vein in the body, usually in the leg. Blood clots that develop in a vein are also known as venous thrombosis. DVT usually occurs in a deep leg vein, a larger vein that runs through the muscles of the calf and the thigh.
[§§§§] Clinical nurse specialist (CNS) is a clinical career pathway for specialist roles in nursing. Specialist practice encompasses a major clinical focus of care to patients and their families in hospital, community and outpatient settings. The specialist nurse works with medical and para-medical colleagues.

of facilitating patient flow in order to take pressure from the emergency department were not working at UHL.

Throughout the inspection, inspectors spoke with a number of patients to ascertain their experiences of receiving care at UHL. All patients were very complimentary about the staff describing them as *'very attentive', 'kind and caring', 'lovely, fantastic, fabulous and very helpful'* and *'brilliant'.* Staff were also described as *'doing their best'* and '*you [patient] couldn't ask for better*.'

When asked what could be improved about the healthcare services at UHL, patients described how the hospital environment was '*noisy'* and how '*the bright lights in the emergency department made it difficult to rest and sleep'*. Trolleys were described as '*uncomfortable'*. Patients described being accommodated on trolleys on the corridor as '*not dignified or private'*. Patients also reflected on how '*there was not enough staff'* and '*staff were overworked'*.

Patient experience times (PETs)[*****] and the time spent waiting for tests were raised by patients in the emergency department as areas of great frustration. One patient described how they waited for four days for a magnetic resonance imaging (MRI) scan[†††††] and seven days for an electroencephalogram (EEG).[‡‡‡‡‡] The experiences recounted by patients were consistent with the hospital's findings from the National Inpatient Experience Survey (NIES) 2022.[§§§§§]

None of the patients who spoke with inspectors during this inspection were aware of the UHL's complaints management process or had received information about the HSE's complaints process '*Your Service Your Say*.'[******] However, patients said they would speak with the clinical nurse manager (CNM) or staff nurse, if needed. Inspectors observed information on *'Your Service, Your Say'* displayed in only one (3A Ward) of the seven clinical areas visited during the inspection.

[*****] Patient experience time (PET) refers to the total time spent by patients within the emergency department, inclusive of time spent awaiting admission.
[†††††] Magnetic resonance imaging (MRI) is a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body.
[‡‡‡‡‡] An electroencephalogram (EEG) is a recording of brain activity.
[§§§§§] The National Care Experience Programme, was a joint initiative from the Health Information and Quality Authority (HIQA), the Health Service Executive (HSE) and the Department of Health established to ask people about their experiences of care in order to improve the quality of health and social care services in Ireland. The National Inpatient Experience Survey (NIES) is a nationwide survey asking patients about their recent experiences in hospital. The purpose of the survey is to learn from patients' feedback in order to improve hospital care. The findings of the NIES are available at: https://yourexperience.ie/inpatient/national-results/.
[******] Health Service Executive. *Your Service Your Say. The Management of Service User Feedback for Comment's, Compliments and Complaints*. Dublin: Health Service Executive. 2017. Available online from https://www.hse.ie/eng/about/who/complaints/ysysguidance/ysys2017.pdf.

Capacity and Capability Dimension

Inspection findings related to the capacity and capability dimension from all clinical areas visited during this inspection (emergency department and inpatient clinical areas) are presented in the following section under national standard 5.2 from the theme of leadership, governance and management.

Inspection findings related to the capacity and capability dimension from the emergency department are presented under two national standards (5.5 and 6.1) from the two themes of leadership, governance and management, and workforce. Other findings related to the quality and safety dimension from the emergency department are also presented in the following sections under two national standards (1.6 and 3.1) from the themes of person-centred care and support, and safe care and support.

Inspection findings related to the capacity and capability dimension from the three inpatient clinical areas visited during this inspection are presented under three national standards (5.5, 5.8 and 6.1) from the themes of leadership, governance and management, and workforce. Key inspection findings leading to the judgment of compliance with the national standards assessed in the capacity and capability dimension are described in the following sections.

Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high-quality, safe and reliable healthcare.

Inspectors found that UHL had defined and integrated corporate and clinical governance arrangements appropriate for the size, scope and complexity of the service provided at UHL, with clear lines of accountability and responsibility. Organisational charts submitted to HIQA detailed the direct reporting arrangements of UHL's governance and oversight committees to ULHG's Executive Management Team (EMT). These arrangements aligned with inspector's findings on inspection. Nonetheless, HIQA found that there was some scope to improve the overall operational functioning of the governance structures at UHL level.

In keeping with the hub and spoke configuration of ULHG, the hospital was governed and managed by the CEO of ULHG supported by the hospital group's EMT. The CEO in turn reported to and was accountable to the HSE's National Director of Acute Operations. Performance meetings between ULHG and the HSE were held monthly, in line with the HSE's performance and accountability framework. Inspectors were satisfied that performance meetings were functioning as intended, meetings were well attended by representatives from ULHG and HSE, and that agreed actions were progressed from meeting to meeting.

ULHG's EMT was chaired by the CEO of ULHG and membership included corporate and clinical representation from across ULHG and core health professions. The EMT met weekly, in line with its terms of reference. Minutes of meetings of the EMT, reviewed by inspectors, showed that meetings followed a structured format, were action-orientated and that the EMT had

oversight of the effectiveness of the UHL's systems and processes to support the delivery of high-quality, safe care. However, HIQA was unable to identify from these records if progress in implementing time-bound actions was monitored from meeting to meeting. Inspectors also noted that the terms of reference for ULHG's EMT were overdue for review and update. For ULHG's EMT to be thoroughly effective as a governing structure, the pace of implementation of agreed actions needs to be clearly monitored. This is essential so as to provide assurances to the EMT that the actions identified by them to improve the quality and safety of healthcare services at UHL are implemented in full and the intended impact and improvement in services are realised.

The Chief Clinical Director and Chief Director of Nursing and Midwifery for ULHG were members of the hospital group's EMT. The Chief Clinical Director provided clinical oversight and leadership to consultants and NCHDs at UHL. The Chief Director of Nursing and Midwifery was responsible for the organisation and management of nursing services at UHL.

Clinical services at UHL were delivered over six sites under the leadership and direction of five clinical directorates. Each clinical directorate was led by a management team comprising a clinical director, general manager, director of nursing, assistant director of nursing and other members assigned with responsibility for risk management and the quality and safety of healthcare services in UHL. Each clinical directorate was responsible for the operational functioning and management of risk for the clinical services under its remit. The directorates also had effective oversight of the performance and the effectiveness of quality initiatives introduced to improve clinical services within their remit. It was clear to inspections that there was a defined reporting arrangement for each clinical directorate to ULHG's EMT and ULHG's Quality and Safety Executive Committee (QualSEC) every three months. The clinical director for each clinical directorate also reported to ULHG's Chief Clinical Director. A sample of the summary reports from the six clinical directorates submitted to QualSEC, reviewed by inspectors were comprehensive, informative and showed that clinical directorates had effective oversight of the quality and safety of the clinical services within their respective remit.

Quality and Safety Executive Committee

ULHG's QualSEC was responsible for the planning, management, implementation and oversight of the hospital's quality, patient-safety and risk management programme. The committee, co-chaired by ULHG's Chief Clinical Director and Chief Operations Officer (COO), met quarterly, in line with its terms of reference. Membership of ULHG's QualSEC included corporate and clinical representation from across ULHG and core professions. It was clear that the committee had a defined reporting and accountability arrangement to ULHG's EMT. The committee delegated elements of its assigned responsibility and function in the areas of infection prevention and control, antimicrobial stewardship, medication safety and deteriorating patient to a number of subcommittees. It was evident that all these subcommittees had defined and formalised reporting and accountability arrangements on a quarterly and annual basis to QualSEC. Minutes of meetings of QualSEC reviewed by

inspectors were comprehensive and it was clear that the committee had effective oversight of the quality and safety of healthcare services provided at UHL.

University Limerick Hospitals Group/Midwest Community Healthcare Organisation Integrated Unscheduled Care Committee

UHL did not have a formal bed management or transition of care committee with responsibility for and oversight of the safe transitions of care. However, performance data on scheduled and unscheduled care activity, and inpatient bed capacity was discussed at weekly meetings of ULHG's EMT, at meetings of the University Limerick Hospitals Group/Midwest Community Healthcare Organisation Integrated Unscheduled Care Committee, and reviewed monthly at performance meetings between the ULHG and HSE.

The University Limerick Hospitals Group/Midwest Community Healthcare Organisation Integrated Unscheduled Care Committee was a new committee established following HIQA's previous inspection. This multidisciplinary committee was assigned with the responsibility to prepare and implement an integrated response to ensure patients accessing unscheduled care at UHL had timely access to care in the most appropriate setting, while optimising patient flow through acute and community services, and improving compliance with national key performance indicators. The committee also monitored the progress of implementation of actions undertaken through the winter/national service plan initiatives and the HSE's Enhanced Community Care[††††††] programme rolled out across MWCH to meet the needs of the population in the Midwest region. From meetings with staff and documentation reviewed by inspectors, it was evident that the committee had oversight of the operational issues impacting on the effective delivery of unscheduled care at UHL.

Co-chaired by ULHG's COO and the Head of Services, Older Persons Service in MWCH, the committee comprised corporate and clinical representation from ULHG, the six hospitals within ULHG and MWCH. The committee met every week, in line with its terms of reference. Minutes of meetings of the committee reviewed by inspectors were comprehensive and showed that the meetings followed a structured format, were action-orientated, and time-bound actions were monitored from meeting to meeting. At the time of this inspection, it was difficult for inspectors to quantify the true effectiveness of this committee because it was a new governance structure only established in October 2022, which needs time to embed. However, the evidence suggests that at the time of this inspection, the committee was functioning as intended over the four months since its establishment. Actions agreed to date, were mainly focused on improving and optimising UHL's utilisation of established community services so as to increase operational effectiveness in the unscheduled care pathway in UHL. The committee reported and was accountable to an oversight committee that included executive members from ULHG and MWCH.

[††††††] The HSE's Enhanced Community Care programme is enhancing and increasing community health services and reducing pressure on hospital services. This means more services closer to where people live. Especially for older people and people with chronic disease. The programme helps health and social care services to manage care at a local level and support the transition from hospitals to the community.

An integrated delayed transfer of care (DTOC) group with representation from acute and community services also met regularly and bi-weekly if necessary to review and discuss cases of DTOC and associated discharge plans across ULHG. The group comprised representatives with responsibility for bed management and patient flow from UHL, Ennis Hospital, Nenagh Hospital and St John's Hospital. Community representation included representatives from older person services, disability services and the homeless action team. The group reported to the University Limerick Hospitals Group/Midwest Community Healthcare Organisation Integrated Unscheduled Care Committee.

UHL also had clear lines of accountability and responsibility for the four areas of known harm assessed during this inspection, with the following committees in place, who reported and were operationally accountable to ULHG's QualSEC.

Infection Prevention and Control Committee (IPCC): Continual improvement of the infection prevention and control practice and hygiene services across ULHG was the responsibility of the well established multidisciplinary IPCC. Chaired by the Clinical Director, this committee met quarterly, in line with its terms of reference. The committee had effective and robust oversight of the implementation of UHL's infection prevention and control annual plan, which set out the objectives and purposeful actions to be achieved at UHL each year. The committee delegated operational elements of its assigned responsibility and function in the areas of hygiene, decontamination, antimicrobial stewardship and *Carbapenemase-producing Enterobacterales* (CPE) to a number of subcommittees. It was clear that these subcommittees had defined and formalised reporting arrangements to the IPCC. Minutes of meetings of the IPCC reviewed by inspectors were comprehensive and showed that meetings followed a structured agenda, were action-orientated and that time-bound actions were progressed from meeting to meeting.

Drug and Therapeutics Committee (DT&C): This committee was responsible for promoting policy and advising and overseeing the safe and appropriate use of medications in UHL and other hospitals in ULHG. St John's Hospital was not a member of ULHG's DT&C as they had their own drugs and therapeutics committee who were responsible for the governance and oversight of medication use in St John's Hospital. The multidisciplinary DT&C comprised corporate and clinical representation from across ULHG including chief pharmacists from UHL and primary care, the chair of the Antimicrobial Stewardship Committee and UHL's medication safety officer. The committee promoted medication safety practices across five hospitals in ULHG. Chaired by the Chief Clinical Director, ULHG's DT&C met monthly, in line with their terms of reference. The committee delegated operational elements of its assigned responsibility and function in the areas of medication safety, antimicrobial stewardship, formulary development, and prescribing and guidance development to a number of subcommittees. It was clear that these subcommittees had defined and formalised reporting arrangements to ULHG's DT&C. The DT&C reported and was accountable to ULHG's QualSEC quarterly. Pharmacy services at ULHG were under the executive management of the Clinical Director of the Diagnostics Directorate who also provided updates to ULHG's EMT weekly. Minutes of meetings of ULHG's DT&C reviewed by inspectors were comprehensive and

showed that meetings followed a structured agenda, were action-orientated and that although actions were not time-bound, their implementation was monitored from meeting to meeting.

Medication Safety Committee (MSC): A medication safety programme was in place in UHL at the time of this inspection. This programme outlined how UHL intended to make measureable improvements in medication safety. The MSC and UHL's medication safety officer were assigned with the responsibility for progressing the implementation of UHL's medication safety programme, with oversight from ULHG's DT&C. Chaired by a medical consultant, the multidisciplinary MSC was to meet monthly to discuss operational issues impacting on the implementation of UHL's medication safety programme. However, minutes of meetings reviewed by inspectors for 2022 showed that the MSC did not meet for a number of months in 2022 because the medication safety officer's position at UHL was unfilled. Monthly meetings of the MSC recommenced with the appointment of a medication safety officer in January 2023.

Antimicrobial Stewardship Committee (AMSC): this multidisciplinary committee had effective oversight of the implementation of UHL's antimicrobial stewardship programme.[‡‡‡‡‡‡] The committee, chaired by a consultant microbiologist met quarterly, in line with its terms of reference and was operationally accountable to ULHG's DT&C and IPCC. Committee membership comprised the chief pharmacist, antimicrobial pharmacist and a consultant in infectious diseases. Inspectors noted that the terms of reference for the committee was overdue for review and update.

Deteriorating Patient Steering Committee (DPSC): oversight and integration of UHL's deteriorating patient improvement programme, including sepsis management was provided by the DPSC. Membership of and the terms of reference for this committee were being reviewed at the time of this inspection. Chaired by the Chief Clinical Director, the committee comprised corporate and clinical representatives from across ULHG. The committee met every two months, reported and was operationally accountable quarterly to ULHG's QualSEC. The committee had oversight of UHL's implementation of and compliance with national guidelines on the early warning systems — Irish National Early Warning System (INEWS),[§§§§§§] Irish Maternity Early Warning System (IMEWS),[*******] and sepsis management.

Good governance structures acknowledge the interdependencies between organisational arrangements and clinical practice, and integrate these to support the delivery of high-quality and safe healthcare. UHL had defined corporate and clinical governance arrangements with clear lines of accountability and responsibility. However, there was scope for improvement with regard to the updating of terms of reference and the monitoring of the implementation

[‡‡‡‡‡‡] An antimicrobial stewardship programme – refers to the structures, systems and processes that a service has in place for safe and effective antimicrobial use.
[§§§§§§] Irish National Early Warning System (INEWS) is an early warning system to assist staff to recognise and respond to clinical deterioration.
[*******] Irish Maternity Early Warning System (IMEWS) is for use in all cases during pregnancy and during the first 42 days after the end of pregnancy irrespective of the gestation and irrespective of the presenting condition of the person.

of agreed actions across all governance committees. Monitoring the implementation of agreed actions is essential to providing assurances to the hospital management that the actions identified to improve the quality and safety of healthcare services at UHL are implemented in full and the intended improvements are realised. Hospital management should also ensure that governance and oversight committees function as intended so as to ensure effective oversight of the quality and safety of the healthcare services provided in UHL.

Judgment: Substantially compliant

Findings relating to the emergency department

Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high-quality, safe and reliable healthcare services.

Since HIQA's last inspection of the emergency department in March 2022, hospital management at UHL have received substantial external supports and resources to strengthen and improve operational effectiveness and efficiencies in the emergency department, at wider UHL level, and to further strengthen and enhance integration with MWCH. Specifically, ULHG and MWCH were supported to:

- enhance and increase operational effectiveness and efficiencies in the unscheduled care pathway with the appointment of a head of operational services at UHL. This person had recently been appointed at the time of this inspection
- maximise the use of community based service models such as home support, aids and appliances and community diagnostics to achieve greater integration and sustainable services between the acute and community sectors. Work was progressing on this measure at MWCH level at the time of this inspection
- implement the HSE's Enhanced Community Care programme across the Midwest region. Work was progressing on this measure at the time of this inspection
- implement the eight Primary Care Networks with chronic disease management teams across the Midwest region to deliver care and services in a non-acute hospital setting and thus avoid hospital admission. Work was progressing on this measure at MWCH level at the time of this inspection
- enhance the ICPOP model of care for older people as a hospital admission avoidance measure. At the time of this inspection, three ICPOP ambulatory care hubs provided specialist geriatric care in Limerick, Ennis and Thurles
- increase consultant medical staffing in UHL's emergency department — approval was granted for an additional two whole-time equivalent (WTE)[†††††††] consultants in emergency medicine, which supported a change to deployment patterns for consultants in the department across seven days

[†††††††] Whole-time equivalent (WTE) is the number of hours worked part-time by a staff member or staff member(s) compared to the normal full time hours for that role.

- increase NCHD medical staffing in UHL's emergency department — approval was granted for an additional 20 WTE NCHDs
- establish a dedicated Geriatric Elderly Medicine Unit (GEMU) for attendees aged 75 years and over who presented to UHL's emergency department. The establishment of this unit was an important hospital admission avoidance measure given the ageing profile of the Midwest region and increasing number of attendees to UHL over the age of 75 years
- expand the OPTIMEND multidisciplinary team in UHL's emergency department by 25 WTE to enable the multidisciplinary assessment of and intervention to patients aged 75 years and over who attend UHL's emergency department. OPTIMEND was up and running at the time of this inspection
- increase resources at UHL for the Rapid Response Frailty team to support the OPTIMEND team. Work was progressing on this measure at the time of this inspection
- re-establish the AMU and ASAU at UHL to function as they should be in line with the HSE's National Acute Medicine Programme's model of care to support continuous, effective patient flow across ULHG. UHL's AMU and ASAU were not functioning as intended at the time of this inspection
- increase GP access to diagnostics in primary care through the provision of a mobile diagnostic service, which was established in the community at the time of this inspection
- increase patient flow coordinator and CNM positions at UHL to specifically focus on patient discharges at weekends. Work was progressing on this measure at the time of this inspection
- implement the 'Red to Green' bed days system[‡‡‡‡‡‡‡] across all clinical areas in UHL to facilitate the identification of patients waiting for diagnostics, review or transfer. The system was implemented in all clinical areas visited during this inspection
- build capacity in the Model 2 hospitals in ULHG by extra resourcing of medical, nursing and administrative staff to enable the AMU in these services operate 8am-8pm over a seven day timeframe, and to allow greater volumes of direct referrals to the units by GPs, thereby avoiding the need to attend UHL's emergency department. The scaling up of the AMUs in Model 2 hospitals across ULHG was underway at the time of this inspection. An additional 50 staff were recruited to the Models 2 hospitals to resource their AMUs. It is projected that this will provide an additional 7,200 slots per year for patients directly referred to the units from GPs

[‡‡‡‡‡‡‡] Red and green bed days' system is a visual management system to assist in the identification of wasted time in a patient's journey. Applicable to inpatient clinical areas in both acute and community settings, this approach is used to reduce internal and external delays as part of the SAFER patient flow bundle.

- introduce the Pathfinder programme,§§§§§§§ providing alternative care at home to people over 65 years of age.

During this inspection, there was evidence that the majority of initiatives arising from the increased support and resourcing of UHL were in the process of being implemented to a greater or lesser extent. However, many of the initiatives introduced had only recently become operational (since January 2023). Consequently, there was some evidence of improvement in operational efficiencies in PETs for admitted and non-admitted patients in the emergency department since March 2022. On discussion with senior HSE management following this inspection, evidence was provided to HIQA (see table below), which showed some recorded gains in early 2023 performance in PETs and flow through UHL's emergency department relative to 2022 figures.

	Total median PET time	Admitted patient median PET time	Non-admitted patient median PET time
2022	9.6 hrs	14.1 hrs	7.6 hrs
January – March 2023	8.6 hrs	12.4 hrs	6.6 hrs

Such improvement was achieved at a time of very significant patient presentation rates. While such improvements had only recently begun to be fully measurable, the improved PETs are encouraging and further demonstrate that, as identified by HIQA in March 2022, improved management practices have an important role to play alongside resourcing to address crowding in UHL's emergency department. Furthermore, it was highlighted to HIQA that some initiatives were still to be employed in full or in part. It is imperative that further opportunities to enhance operational efficiency in UHL's emergency department are implemented to continue to build on the identified gains in recent months.

At operational level, there was evidence that a number of meetings with representation from the acute and community services were held to manage the demand for unscheduled care at UHL. Some of these meetings were already in place at the time of HIQA's last inspection, while others (Unscheduled Care Steering Group and Long Stay Tuesday) were established after that inspection. These meetings included the:

- **Acute floor collaboration:** this meeting comprised multidisciplinary clinical representatives from the clinical areas that form the Acute Floor — emergency department, AMAU and ASAU, the general manager for unscheduled care, infection prevention and control representation and a consultant microbiologist. The group met every two weeks to ensure optimal patient management and identify measures to address patient flow

§§§§§§§ Pathfinder programme is a collaborative service staffed by ULHG's allied health staff and the HSE's National Ambulance Service, with the aim to change the current model of conveyance to the emergency department following a 999 call for over 65 year olds with low acuity. Pathfinder is provided Monday to Friday from 8am-8pm in the Limerick region.

challenges in UHL's emergency department, which had implications for the AMAU and ASAU.

- **Unscheduled Care Steering Group:** membership of this group comprised corporate and multidisciplinary clinical representatives from ULHG and the six hospitals in ULHG. The group met every two weeks to discuss activity and identify measures to improve patient flow across ULHG.
- **ED huddle:** this multidisciplinary meeting, comprised representatives from UHL's emergency department team, patient flow team, a senior nurse manager for medicine and assistant director of nursing. The huddle focused on operational issues, reviewed emergency department activity and the clinical need and prioritisation of patients for inpatient beds in the main hospital.
- **Hospital Management Team:** membership for this meeting comprised representatives from the six hospitals in ULHG, including all six directorates, representatives from MWCH and leads for unscheduled care, patient flow and diagnostics. The purpose of the meeting was to support and improve patient flow in the unscheduled care pathway by identifying bed availability across ULHG and community services, reviewing any DTOC to identify and manage any challenges to patient discharge and raising any operational issues that could impact on patient flow. At the time of this inspection, HIQA found that DTOC was less of a factor in explaining ineffective patient flow in UHL relative to many of its peer hospitals nationally – albeit still an important one in need of continued active management. Documentation reviewed by inspectors showed that for the three week period preceding HIQA's inspection, the rate of DTOC at UHL ranged from 19 to 27 patients per day, with the longest waiting time being 247 days. This rate of DTOC in UHL was lower when compared to other Model 4 hospitals inspected to date by HIQA. DTOC in UHL was mainly due to the complexity of care and support needed by patients, the limited number of rehabilitation and nursing home beds in the community, a delay with accessing diagnostics and or a delay in accessing homecare support packages. The number of DTOC were tracked and monitored by the University Limerick Hospitals Group/Midwest Community Healthcare Organisation Integrated Unscheduled Care Committee. During this inspection, hospital management told inspectors of their intentions to introduce further measures to assist the timely discharge of patients, including criteria based discharging, discharge before 11am and speciality cohorting of all patients.
- **Long Stay Tuesday meetings:** this meeting was chaired by the head of bed management at UHL and comprised representatives from the patient flow team, health and social care professionals, nursing and MWCH. Meetings were held weekly to review all patients with a length of stay of 10 days or more. The aim was to support and improve patient flow and discharge planning across ULHG. Documentation reviewed by inspectors show that UHL's average length of stay (ALOS) for medical and surgical inpatients was not a contributing factor to ineffective patient flow in UHL. UHL's ALOS for medical patients was 3.76 days (HSE's national target of ≤7.0 days) and for surgical patients was 3.28 days (HSE's national target of ≤5.2 days). This further indicated to inspectors that a core

contributing factor impacting on inpatient bed availability at UHL was insufficient patient flow due to inadequate bed stock across ULHG.

During this inspection, HIQA also found evidence of several other measures in place at UHL to facilitate the timely review and discharge of patients. These included:

- multidisciplinary discharge planning
- ward rounding in the general medical and peri-operative ward daily
- cohorting of surgical, renal and cardiology patients
- predicative patient discharge
- using the SAFER******** patient flow bundle in all clinical areas
- using the 'Red to Green' bed days system to identify the challenges to discharge and the issues with transfer of care
- building of an additional 96-bed block to further increase the bed stock at UHL and ensure consistency in bed numbers with other Model 4 hospitals.

In addition, the CEO of ULHG had commissioned an independent review of patient flow across ULHG. The review report, published in September 2022, included a series of recommendations to support and better improve patient flow across ULHG. The CEO of ULHG discussed the plans happening at ULHG level to implement the recommendations of the patient flow review.

Similar to previous findings, during this inspection, inspectors observed the emergency department to be grossly overcrowded with a total of 121 patients registered in the department at 11am. This was 153% more than its intended planned capacity at any given time. Fifty-five (45%) of the 121 registered patients were boarding in the emergency department while awaiting an inpatient bed in the main hospital. This percentage was almost identical to the 43% of patients found to be boarding in the emergency department during HIQA's previous inspection.

All attendees to the emergency department was triaged and assigned to the relevant prioritisation category levels 1-5 in line with the Manchester Triage System.†††††††† At 11.00am on the first day of inspection, the waiting time from:

- registration to triage ranged from 0 mins to 98 minutes (I hour 38 minutes). The average waiting time was 25 minutes

******** The SAFER patient flow bundle is a practical tool comprising five elements to reduce delays for patients in adult inpatient wards (excluding maternity). S - Senior Review - all patients have a senior review by a consultant or by a registrar enabled to make management and discharge decisions. A - All patients have a predicted discharge date. F - Flow of patients to commence at the earliest opportunity from assessment units to inpatient wards. E - Early discharge - patients discharged from inpatient wards early in the day. R – Review - a systematic multidisciplinary team review of patients with extended lengths of stay.

†††††††† Manchester Triage System is a clinical risk management tool used by clinicians in emergency departments to assign a clinical priority to patients, based on presenting signs and symptoms, without making assumptions about underlying diagnosis. Patients are allocated to one of five categories, which determines the urgency of the patient's needs.

- triage to medical review ranged from 2 minutes to 604 minutes (10 hours). The average waiting time was 128 minutes (2 hour 13 minutes)
- decision to admit to actual admission in an inpatient bed ranged from 47 minutes to 7,945 minutes (132 hours). The average waiting time was 1,844 (30 hours 44 minutes).

When compared to HIQA's last inspection, there was an improvement in the waiting times for triage and medical review, which demonstrated the operational efficiencies gained in the emergency department as a result of the increased supports and resourcing of UHL. However, on the whole, the gains were marginal because the mismatch between demand and capacity for inpatient beds remained, which resulted in a substantive number of patients (45%) boarding in the emergency department and continued to be a key casual factor of the prevailing overcrowding of the department. The overcrowding of UHL's emergency department will impact on the timely triage and medical review of patients. Practicalities such as having to wait for a suitable physical space to conduct a thorough and detailed assessment of patients will impact on the timely review of patients. Nevertheless, the measures implemented to date, have brought UHL in line with the triage and medical review waiting times for other Model 4 hospitals inspected to date by HIQA.

On the days of this inspection, hospital management had enacted the full escalation (level 3) protocol in response to the level of overcrowding in UHL's emergency department. UHL's escalation plan, internal escalation processes and the triage risk mitigation and escalation process had been revised since HIQA's last inspection. This resulted in the development and ratification of a revised escalation framework and an eight step internal escalation plan for UHL's emergency department. The revised escalation plan and processes had been introduced at the beginning of February (three weeks before HIQA's inspection) and on the day of inspection its impact on the waiting times from registration to triage and from triage to medical review showed some improvement.

Similar to previous inspection findings, other systems and processes in place at UHL were not functioning as might be expected in a hospital with better flow of patients. The hospital's AMU and ASAU were not functioning properly as an alternate flow pathway for patients in order to take pressure from the emergency department. Fourteen (55%) of the 25 patients in the AMU were admitted and awaiting an inpatient bed in the main hospital. Ten (71%) of the 14 admitted patients were boarding in the AMU more than five days. Over a quarter of the patients in the ASAU were boarding there while awaiting an inpatient bed in UHL.

Overall, HIQA previously identified scope for better management arrangements to support the delivery of safe and reliable services in UHL's emergency department, which was further validated by the HSE's support team. Some improvements and efficiencies have been made, but there is further scope for improvement to fully address the issues that impact on the effective flow of patients in UHL's emergency department, and the wider issues impacting on patient safety at UHL. Noting the continued requirement for incremental improvement in this area, HIQA found the hospital to be partially compliant with this national standard. The

additional supports and resourcing received by ULHG and UHL and the resulting initiatives, have resulted in some recent improvements in the waiting times for triage and medical review, but the gains have by the HSE's own acknowledgment yet to realise their full potential. Similar to March 2022, during this inspection UHL's emergency department was found to be grossly overcrowded, with almost half the patients in the department admitted under specialist teams and boarding in the department while waiting for an inpatient bed in the main hospital.

It is imperative that the management arrangements continue to evolve to further enhance the much needed efficiencies and improvements to successfully address the issue of ineffective patient flow and insufficient inpatient capacity affecting the operational effectiveness of UHL's emergency department. It is recognised and acknowledged that UHL lacks much needed capacity and this continues to be a key factor contributing to ineffective flow of patients through UHL. While it will take time for the effect of the range of measures introduced since HIQA's March 2022 inspection to be fully realised, inspectors have identified some improvements in both resourcing and work practices to improve efficiencies in UHL. These efforts remain a work in progress and need to be reinforced following this inspection. Management efforts need to continue to evolve to more effectively drive and sustain operational efficiencies while also effectively preparing for and managing the extra bed capacity planned in the long-term.

Judgment: Partially compliant

The following section outlines other findings from the inspection related to the emergency department. Findings and judgments of compliance are presented under three national standards (6.1, 1.6 and 3.1) from the themes of workforce; person-centred care and support; and safe care and support.

Standard 6.1 Service providers plan, organise and manage their workforce to achieve the service objectives for high-quality, safe and reliable healthcare.

Medical staffing levels in UHL's emergency department were maintained to support the provision of 24/7 emergency care. This was in part due to the uplift in medical staffing approved for the emergency department since HIQA's last inspection.

In total, the emergency department now has an approved funding for 11 WTE consultants in emergency medicine, with all 11 WTE positions filled at the time of this inspection — nine on a permanent and two on a temporary basis. One of the 11 WTE consultants in emergency medicine was the assigned clinical lead for the emergency department and was responsible for the day-to-day functioning of the department. Consultants in the emergency department were operationally accountable and reported to the hospital's Clinical Director. All consultants in emergency medicine were on the specialist register with the Irish Medical Council. The uplift in the number of consultants in emergency medicine, ensured a senior clinical decision-maker at consultant level (often two consultants) was on-site in the hospital's emergency

department each day 8.00am to 8.00pm, with availability on a 24/7 basis. One consultant in emergency medicine was on-site in UHL's emergency department from 8.00am to 1.00pm on Saturday and Sunday. This represented progress since HIQA's inspection of March 2022. Attendees to the emergency department were assigned to the consultant on call until admitted or discharged. If admitted, the patient was admitted under a specialist consultant and boarded in the emergency department while awaiting an inpatient bed in the main hospital.

The hospital was an approved training site for NCHDs on the basic and higher specialist training schemes in emergency medicine. Consultants in emergency medicine were supported by 46 WTE NCHDs at registrar (25 WTE), senior house officer (SHO) (20 WTE) and intern (1 WTE) grades. This included an uplift of 20 WTE NCHDs since March 2022. On the day of inspection, 37 (80%) of the 46 WTE approved and funded NCHDs positions were filled. An additional six SHOs were recruited and were due to commence employment in the emergency department in April 2023.

In summary, since HIQA's last inspection, UHL's emergency department gained an additional two WTE consultants in emergency medicine and 20 NCHDs at registrar and SHO grades. This uplift in medical staff has enabled some operational and clinical efficiencies to be achieved as evident in some improvements in the PETs. It is imperative that these gains are built on and further efficiencies are gained from the resulting redeployment of work practices in the department, increased availability of senior decision-makers at consultant level and revised escalation procedures.

Nursing workforce

UHL's emergency department's approved and funded complement of nursing staff (including management grade) was 125.79 WTE. The department's nursing staff complement had increased when compared to the approved and funded nursing staff complement (including management grades) in place at the time of HIQA's previous inspection, which is a positive development. The increase represents the additional 21.5 WTE nursing positions aligned with the staffing requirement determined under the *Framework for Safe Nurse Staffing and Skill Mix in Adult Emergency Care Settings in Ireland*. While the increase in nursing staff was needed to meet service demand, hospital management continue to experience challenges in filling nursing positions. At the time of this inspection, 27.52% (34.62 WTE) of the department's nursing staff positions were unfilled. Hospital management were managing the deficit in nursing staff levels through an ongoing bespoke recruitment campaign and the use of agency nurses. Nursing staff in the emergency department were supported by 29.26 WTE healthcare assistants. A third (32.81%) of these positions were unfilled at the time of this inspection.

It was difficult to fully quantify the specific impact that the vacant positions in nursing and healthcare assistant staff were having on the care delivered in UHL's emergency department because staff were not quantifying the proportion of care delayed, unfinished or omitted. The improvement in triage waiting times would suggest that the revised triage escalation

procedures, which resulted in the redeployment of additional nursing staff to triage at times of increased demand has being progressive in enabling the timely triage of patients presenting to UHL's emergency department.

Staff uptake of essential and mandatory training

It was evident from staff training records reviewed by inspectors that nursing staff in UHL's emergency department undertook multidisciplinary team training appropriate to their scope of practice every two years. Essential training relevant to the four areas of harm was overseen by the CNMs and three WTE clinical skills facilitators. Staff were required to complete mandatory and essential training in infection prevention and control, medication safety and INEWS on the HSE's online learning and training portal (HSELanD). Nursing, medical and support staff who spoke with inspectors confirmed that they had received formal induction training. Training records reviewed by inspectors showed that the uptake of essential and mandatory training in basic life support, early warning systems, hand hygiene and sepsis management was satisfactory.

In general, inspectors were satisfied there were sufficient staffing levels and arrangements in place to provide baseline levels of services safely in UHL's emergency department on the days of inspection. This was in part due to the uplift in medical and nursing staff since HIQA's last inspection, but it also reflected more appropriate staff deployment patterns across the working week and in response to fluctuations in service demand. Notwithstanding this, the emergency department had a number of unfilled positions across medical, nursing and healthcare assistant staff, which hospital management were managing in the short-term. It should be noted that many of the nursing deficits reflected a revision upward in planned staffing numbers in response to a new staffing initiative - a situation which is currently not unique to UHL as other services are also working to enhance staffing numbers in response to this development. On the day of inspection, HIQA did not identify any specific immediate impact that these staffing shortfalls were having on care delivered in the emergency department, and prior concerns that HIQA found related to delayed patient triage had been addressed. However over time, running services with such staffing deficits can have an impact on service sustainability and staff retention, meaning that further efforts are required to address ongoing staff vacancies. Like other hospitals, hospital management at UHL were challenged in their efforts to recruit medical and nursing staff, but were persistent in their endeavours to recruit staff through multiple bespoke recruitment campaigns. In comparing findings with those identified in March 2022 however, inspectors were satisfied that while the ongoing staffing situation was not ideal, it had improved and that service risks had been reduced as a result. Consequently, a judgment of partially compliant for this inspection against this national standard in the emergency department was achieved – an improvement on the non-compliant finding of March 2022.

Judgment: Partially compliant

Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.
Staff working in UHL's emergency department were committed to promoting a person-centred approach to care, but were hampered in doing this by the challenges of an overcrowded department. Inspectors found the situation in which patients were boarding in the department were similar to the inspection findings of March 2022. The emergency department was grossly overcrowded with 121 registered patients in the department at 11.00am. The number of patients in the department at that time was nearly three times over the intended capacity of 49. The 72 additional patients were accommodated on trolleys and chairs throughout the department. Staff did try to promote and protect patient's privacy, dignity and respect. Privacy and dignity was supported for patients accommodated in individual cubicles in the emergency department, but the dignity, privacy and confidentiality of patients accommodated on trolleys was significantly compromised. Privacy curtains were used when administering care to patients, but their effectiveness was limited in a grossly overcrowded department. The bereavement room was used for patients at or near the end of life in the emergency department. Patients were supported with their individual needs. Two Patient Advocacy and Liaison Services (PALS) managers supported and advocated for patients, especially older patients, attending UHL's emergency department. There was evidence that person-centred hospital admission avoidance initiatives such as OPTIMEND, GEMU, ICPOP hubs and Community Intervention Teams (CIT),‡‡‡‡‡‡‡‡ which included multidisciplinary teams (MDCIT) were used to ensure patients were seen by the right team in the right setting. However, documentation reviewed by inspectors would suggest that these services could be better utilised and the number of referrals to the services could be greater. Community based services might be used more effectively for patients that met the referral criteria and in doing so may, along with other measures, this may contribute to and help avoid hospital admission, improve patient flow and inpatient bed availability at UHL. These findings were consistent with the findings of the 2022 NIES, where UHL scored significantly lower than the national scores in questions related to experience of respect and dignity and waiting times in the emergency department. Overall, there were some examples of privacy, dignity and autonomy being promoted in UHL's emergency department, but any meaningful impact was negated by the overcrowding of the department. The advocacy service for patients in the emergency department and the ongoing promotion of alternate pathways for some patients attending the department demonstrated some improvements. However, the persistent overcrowding in UHL's emergency department negatively impacted on any meaningful promotion of patients' human rights for the vast amount of patients in the department. Inspectors did not observe any significant change to the environment where patients were boarded and or in the promotion and respecting of patients' privacy, dignity and autonomy since HIQA's last inspection in March 2022. For this

‡‡‡‡‡‡‡‡ Community Intervention Teams are nurse-led teams, supported by other healthcare professionals and services that provide a rapid and integrated approach to delivering specific clinical interventions to eligible patients within their own home.

reason, during this inspection, the emergency department was found to be still non-compliant with this national standard.

Judgment: Non-compliant

Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.

UHL collected data on a range of different quality and safety indicators related to the emergency department, in line with the national HSE reporting requirements. Data was collated on the number of presentations to and admissions from UHL's emergency department, ambulance turnaround times, DTOC and ALOS. Collated performance data and compliance with national key performance indicators for emergency care was reviewed at meetings of the medical directorate, ULHG's QualSEC and ULHG's EMT.

Emergency department related risks were managed at department level with oversight of the process assigned to the CNM3. Serious high-rated risks were escalated to the medical directorate's Serious Incident Management Team (SIMT) and were along with mitigation actions recorded on the directorate's risk register. Serious high-rated risks were escalated to ULHG's EMT and recorded on UHL's corporate risk register. Overcrowding in the emergency department was a high-rated risk on UHL's corporate risk register, with corrective actions and controls applied to mitigate potential and actual risks to patient safety. The impact of the mitigating actions, implemented to date to address patient safety risks arising from the overcrowding of UHL's emergency department was limited. At 11.00am on the day of inspection, the hospital was not compliant with any of the national key performance indicators for emergency departments set by the HSE. At that time:

- 61 (50%) attendees to UHL's emergency department were in the department for more than six hours after registration — not in line with the national target which requires that 70% of attendees are admitted to a hospital bed or discharged within six hours of registration in the emergency department.
- 58 (48%) attendees to UHL's emergency department were in the department for more than nine hours after registration — not in line with the national target of 85% of attendees being admitted to a hospital bed or discharged within nine hours of registration in the emergency department.
- 24 (20%) attendees to the emergency department were in the department for more than 24 hours after registration — not compliant with the national target that 97% of patients are admitted to a hospital bed or discharged within 24 hours of registration in the emergency department.
- 19% (23) of all attendees to the emergency department were aged 75 years and over. 16 (69%) of these patients were in the department for more than nine hours after registration — not in line with the national target that 99% of patients aged 75 years

and over are admitted to a hospital bed or discharged within nine hours of registration in the emergency department.

- 9 (39%) attendees to the emergency department aged 75 years and over were in the department for more than 24 hours after registration — not in line with the national target that 99% of patients aged 75 years and over are admitted to a hospital bed or discharged within 24 hours of registration in the emergency department.

Infection prevention and control

A COVID-19 management pathway was in place in UHL's emergency department. At point of entry to the hospital, attendees were screened for signs and symptoms of COVID-19, in line with the national guidance in place at the time of this inspection. Symptomatic patients had access to COVID-19 rapid testing. The infection status of each patient was recorded on the hospital's electronic information system. A prioritisation system was used to allocate patients to the single cubicles with oversight from UHL's infection prevention and control team. A nurse from the infection prevention and control team visited the emergency department daily during core working hours. Staff in the department had access to a microbiologist 24/7. The emergency department was generally observed to be clean and well maintained during the inspection. Staff confirmed that terminal cleaning[§§§§§§§§] was carried out following suspected or confirmed cases of COVID-19. Environmental and equipment hygiene audits were carried out in the department monthly, with action plans developed to improve any areas of non-compliance. This is discussed further under national standard 2.8. Adequate physical distancing was not maintained between trolleys on the corridor in the emergency department and this posed a significant infection prevention and control risk for patients.

Medication safety

A clinical pharmacist provided support to the emergency department when required. Medication reconciliation was carried out by the clinical pharmacist and NCHDs on admitted patients. Medication stock control was maintained by pharmacy technicians. Staff in the department had access to an antimicrobial pharmacist.

Deteriorating patient

The Emergency Medicine Early Warning System (EMEWS)[*********] was not implemented in UHL, but hospital management were planning to introduce the system when the emergency department had its full complement of nursing staff. INEWS was used for admitted patients. Staff training on the early warning system was facilitated by the clinical skills facilitators assigned to the emergency department.

[§§§§§§§§] Terminal cleaning refers to the cleaning procedures used to control the spread of infectious diseases in a healthcare environment.

[*********] Emergency Medicine Early Warning System (EMEWS) is a national clinical guideline developed by the HSE's National Clinical Programme for Emergency Medicine launched in 2018 by the Minister for Health. It applies to adults patients (16 years and older) attending an emergency department in Ireland.

Safe transitions of care

The Identify, Situation, Background, Assessment and Recommendation ($ISBAR_3$) communication tool[††††††††] was used for internal and external patient transfers to and from UHL's emergency department and for staff clinical handover.

Management of complaints

HIQA was assured that complaints related to the emergency department were managed locally by CNMs with oversight from the CNM3, in line with UHL's complaints policy and the HSE's '*Your Service You Say*'. Complaints relating to the emergency department were tracked and trended by the complaints manager assigned to medical directorate and feedback on emerging trends was presented to clinical staff in the emergency department.

Overall summary

While the review and introduction of the escalation protocol in UHL's emergency department was seen as a positive tool to support risk identification and mitigation, inspectors were not satisfied that the arrangements in place were fully effective in managing the risks of harm to the substantial number of patients in the emergency department during this inspection. As a result and as evident by the PETs, patients were waiting long periods in the emergency department, and in doing so, were exposed to a higher level of risk and harm. Considering the association of prolonged waiting times in the department with increased morbidity and mortality, this remained a concern for HIQA. There was some evidence that the short and medium-term measures were beginning to impact positively on patient flow, but the fundamental issues of insufficient inpatient capacity and persistent high levels of attendance to UHL's emergency department remained. HIQA acknowledges there are plans to address inpatient capacity in the longer term, but in the interim hospital management need to continue to ensure effective measures are implemented to protect the high numbers of patients receiving care in UHL's emergency department from any potential and actual risk of harm arising from an overcrowded department. Notwithstanding these challenges, HIQA was able to rate this national standard as partially compliant for this inspection, an improvement on the non-compliant rating achieved in March 2022.

Judgment: Partially compliant

[††††††††] Identify, Situation, Background, Assessment and Recommendation (ISBAR) communication tool is a structured framework which outlines the information to be transferred in a variety of situations, such as bedside handover, internal or external transfers (for example, from nursing home to hospital, from ward to theatre), communicating with other members of the multidisciplinary team, and upon discharge or transfer to another health facility.

Inspection findings relating to the wider hospital and three inpatient clinical areas visited

This section of the report describes findings relating to the wider hospital and three inpatient clinical areas visited during the inspection in the capacity and capability dimension. It sets out the judgments of compliance with the three national standards (5.5, 5.8 and 6.1) from the themes of leadership, governance and management and workforce.

Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high-quality, safe and reliable healthcare services.

During this inspection, UHL had the following management arrangements in place with devolved autonomy and decision-making for the four areas of known harm for the wider hospital and inpatient clinical areas visited.

Infection, prevention and control

ULHG had a well resourced infection prevention and control team comprising:

- 2 WTE consultants in infectious diseases
- 3 WTE consultant microbiologists
- 3 WTE microbiology NCHDs
- 2 WTE Assistant Director of Nursing (ADON)
- 8 WTE CNM2. At the time of this inspection, 4.25 (53%) WTE CNM2 positions were filled
- 2 WTE staff nurses
- Intravenous Venous Infusion (IVI) team comprising 1 WTE CNM3 and 4 WTE staff nurses
- 1 WTE staff nurse with responsibility for surgical site surveillance
- 1 WTE informatics staff nurse
- 5 WTE antimicrobial pharmacist
- 3 WTE surveillance scientists. At the time of this inspection, 2 (67%) WTE surveillance scientist positions were filled at UHL.

The hospital did not have a formalised overarching infection prevention and control programme[‡‡‡‡‡‡‡‡‡] as per national standards. However, UHL had a comprehensive infection prevention and control plan that set out the infection prevention and control objectives and

[‡‡‡‡‡‡‡‡‡] An agreed infection prevention and control programme as outlined in the *National Standards for the Prevention and Control of Healthcare-Associated Infections in Acute Healthcare Services* (2017), sets out clear strategic direction for the delivery of the objectives of the programme in short, medium and long-term as appropriate to the needs of the service. Available online from: https://www.hiqa.ie/reports-and-publications/standard/2017-national-standards-prevention-and-control-healthcare.

plan of work to be achieved each year. ULHG's IPCC had oversight of the progress in implementing the objectives and purposeful actions in the annual plan.

Medication safety

UHL had approved funding for 75 WTE pharmacists which included basic and senior grade pharmacists. At the time of this inspection, 51 (68%) WTE pharmacist positions were filled at UHL. The hospital was also approved and funded for 43.5 WTE pharmacy technicians, with 32.5 (75%) WTE positions filled at the time of this inspection. UHL had a formal medication safety programme, which comprised short, medium and long-term objectives to support medication safety practices at the hospital. UHL's medication safety officer was assigned with the responsibility for implementing the medication safety programme with support from the MSC and oversight from ULHG's D&TC. HIQA was satisfied that hospital management were actively working to recruit pharmacists and pharmacy technicians through a bespoke, targeted recruitment campaign but like other hospitals inspected by HIQA, they were encountering major challenges in their efforts to recruit such staff. The shortfall in pharmacy staff significantly impacted on the ability to provide a comprehensive clinical pharmacy service,§§§§§§§§§ which included a clinical pharmacist-led medication reconciliation service for all clinical areas. Pharmacy staffing levels was a high-rated risk recorded on UHL's corporate risk register, with appropriate corrective actions and controls applied to mitigate the potential risk to patent safety arising from the shortfall in pharmacy staffing.

Deteriorating patient

UHL had a deteriorating patient improvement programme. The relevant early warning score for non-pregnant adult patients — INEWS version 2 and the ISBAR$_3$ communication tool were implemented in UHL. In addition, at the time of this inspection, hospital management were in the process of establishing an outreach critical care team. This team comprised one WTE Advanced Nurse Practitioner (ANP)********** and a candidate ANP, who along with NCHDs reviewed patients discharged from the hospital's Intensive Care Unit, patients with a triggering early warning score and attended cardiac arrests in clinical areas during core working hours. Staff training on the use and escalation protocol for early warning systems was provided across UHL by clinical skills facilitators.

Transitions of care

Since HIQA's last inspection, the hospital group received significant resourcing to strengthen the integration and collaboration with community services in MWCH. The aim was to improve patient flow through and from UHL and the wider hospital group. The effectiveness of this integration was overseen by the University Limerick Hospitals Group/Midwest Community Healthcare Organisation Integrated Unscheduled Care Committee. An additional assistant bed

§§§§§§§§§ Clinical pharmacy service - is a service provided by a qualified pharmacist which promotes and supports rational, safe and appropriate medication usage in the clinical setting.

********** Advanced practice nursing is a defined career pathway for registered nurses, committed to continuing professional development and clinical supervision, to practice at a higher level of capability as independent autonomous and expert practitioners.

manager (grade VII) and nine patient flow coordinators (grade V) were recruited to strengthen the patient flow team at UHL and ensure patient discharge occur over a seven day period. At the time of this inspection, six WTE patient flow coordinator positions were filled and the remaining three WTE coordinators were due to commence employment by the end of April 2023. Overall, when compared to other Model 4 hospitals, the patient flow team at UHL was well resourced.

In summary, the hospital had functioning management arrangements in place to manage, support and oversee the delivery of high-quality, safe and reliable healthcare services in the four areas of known harm at wider UHL level. Notwithstanding this, further enhancement of the managerial arrangements to manage service change and demand, including ensuring adequate staffing is needed at UHL. The shortfall between the approved and actual numbers of pharmacy staff did impact on the ability to provide a comprehensive clinical pharmacy service in UHL. The recently strengthened patient flow team was well resourced however, all approved and funded extra positions for patient flow coordinators were not filled. It is possible that this could have implications for the proposed plan to scale up the timely discharge of patients over seven days and will further impact on patient flow and inpatient capacity across UHL.

Judgment: Substantially compliant

Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.

UHL had monitoring arrangements in place for identifying and acting on opportunities to improve the quality, safety and reliability of healthcare services. The hospital reported on a range of national quality and patient safety performance indicators, in line with the national HSE reporting requirements. There was evidence that information from this process was being used to improve healthcare services at UHL, but there is scope of improvement in this area.

Risk management

HIQA was assured that UHL had formalised structures and processes in place to manage and oversee the management of identified risks. Risks were identified, managed and monitored locally at clinical area level, at clinical directorate level and by ULHG's EMT. Risks identified at local clinical area level were recorded on local risk registers. CNMs were assigned with the responsibility for identifying and implementing corrective actions and controls to mitigate any potential and actual risks to patient safety. More serious high-rated risks not managed at clinical area level were escalated to clinical directorate level. Each clinical directorate had a risk and patient safety advisor and a SIMT who were responsible for ensuring identified risks were managed appropriately and effectively. It was clear that the effectiveness of the actions to manage and mitigate identified risks were overseen by each clinical directorate and ULHG's

QualSEC. High-rated risks not managed at clinical directorate level were escalated to ULHG's EMT and recorded on UHL's corporate risk register. High-rated risks not managed at ULHG level were escalated and discussed at the monthly performance meetings between ULHG and the HSE.

Audit activity

There was a coordinated approach to the management of clinical auditing at UHL. The Clinical Audit Committee had oversight of all clinical audit activity and the implementation of quality improvement plans arising from audit findings across ULHG. The committee had a defined reporting arrangement to ULHG's QualSEC. Audit findings were also a standing agenda item for meetings of ULHG's IPCC, DT&C and DPSC. Each clinical directorate was responsible for overseeing the conduct of audits and the monitoring of implementation of all quality improvement plans for the clinical services within their remit. While inspectors found a coordinated approach to the process and oversight of auditing at UHL, there was scope for improvement in the number of audits carried out and how findings could be used to improve medication safety practices, care delivered to the deteriorating patient and the safe transitions of care. This is discussed further under national standard 2.8.

Management of serious reportable events

As part of this inspection, inspectors gathered detailed evidence on the current assurance oversight and the processes relating to the reporting of serious reportable event at UHL. The hospital's rate of reporting of serious reportable events was also benchmarked against other Model 4 hospitals. Inspectors also reviewed findings of an audit of compliance with the reporting of serious reportable to the National Incident Management System (NIMS)[††††††††††] carried out by UHL.

Inspectors were satisfied that, at the time of this inspection, there was proactive identification, monitoring, analysis and effective oversight of the management of serious reportable events at UHL. Serious reportable events and serious incidents were managed at clinical directorate level by each clinical directorate's SIMT. The clinical directorate's SIMT provided oversight of, and ensured that the reporting, reviewing and management of category one serious incidents[‡‡‡‡‡‡‡‡‡‡] that occurred in the directorate were managed in line with the HSE's Incident Management Framework. Chaired by the clinical directorate's Clinical Director, the directorate's SIMT met every two weeks and core membership comprised the directorate's general manager, director of nursing and risk and patient safety advisor, with other relevant persons invited when needed. Each clinical directorate had a defined reporting arrangement to ULHG's QualSEC. Serious reportable events that had a hospital-wide

[††††††††††] The National Incident Management System (NIMS) is a risk management system that enables hospitals to report incidents in accordance with their statutory reporting obligation to the State Claims Agency (Section 11 of the National Treasury Management Agency (Amendment) Act, 2000).
[‡‡‡‡‡‡‡‡‡‡] Category one incident is a clinical and non-clinical incidents rated as major or extreme as per the HSE's risk impact table.

implication and or those not managed at clinical directorate level were escalated to ULHG's SIMT, which was chaired by the Chief Clinical Director and met every two to three months.

Management of patient-safety incidents

UHL had a defined system and process in place to proactively identify, manage and report patient-safety incidents. Patient-safety incidents were managed at clinical directorate level with oversight by the clinical directorate's SIMT and reported to NIMS. It was evident from documentation reviewed by inspectors and meetings with staff representatives that patient-safety incidents were tracked and trended by each clinical directorate's risk and patient safety advisor and feedback on emerging trends was presented to clinical staff. A detailed incident management report, which outlined compliance with relevant key performance indicators was compiled at the end of each year by the risk and patient safety department, and submitted to ULHG's QualSEC and ULHG's EMT. Patient-safety incidents related to the four areas of known harm are discussed further under national standard 3.3.

Feedback from people using the service

UHL's findings from NIES were reviewed at meetings of ULHG's QualSEC and relevant updates were provided to each clinical directorate and at meetings of ULHG's EMT. At the time of this inspection, there was evidence that hospital management was working with the HSE to implement quality improvement initiatives, in response to the NIES findings. Areas of focused improvement included nutrition for patients, communication with patients and families and access to written information about going home from hospital. The process and pace of implementation of quality improvement plans was overseen by each clinical directorate, and an update on the pace of progress was included in the directorate's quarterly report to ULHG's QualSEC.

Overall, the hospital had systematic monitoring arrangements in place to identify opportunities to improve the quality, safety and reliability of the healthcare services at UHL. Performance against key performance indicators in the four areas of harm was monitored and there was evidence that information from this process was being used to improve the quality and safety of healthcare services and patients' experiences of receiving care at UHL. Quality improvement initiatives were implemented in response to audit findings, patient-safety incidents and feedback from people using the service. However, there is scope for improving risk management processes at local clinical area level. There is also scope to improve the auditing activity in the area of medication safety, deteriorating patient and transitions to care, so that all opportunities are used to improve the quality of healthcare services at UHL.

Judgment: Substantially compliant

Standard 6.1 Service providers plan, organise and manage their workforce to achieve the service objectives for high-quality, safe and reliable healthcare.

Workforce was a standing agenda item for the monthly meeting of the hospital group's EMT and the monthly performance meeting between ULHG and the HSE. Staffing was also a high-rated risk recorded on UHL's corporate risk register. Since HIQA's previous inspection, UHL and MWCH have gained a total of 70 new positions across clinical, medical administration, diagnostics and community services, which included the head of operational services position at UHL.

Medical workforce

The hospital had an approved funding for a total of 239 WTE medical consultants across a range of specialties. The number of medical consultants in position at the time of this inspection was 215 WTE, with 24 (10%) WTE consultant positions unfilled. Hospital management were recruiting medical consultants through a continual, bespoke recruitment campaign. A small number of doctors working as consultants who were not on a relevant specialist register with the Irish Medical Council were employed by UHL. Inspectors were assured that supports were in place for these consultants and that the supports were aligned to those recommended by the HSE. A new consultant rota was introduced at UHL the week of this inspection. This rota was based on a 'distributive take model' approach, where admitted patients were distributed across the medical and surgical teams the day after rostered on call. This should result in a better shared work load among consultants at UHL, which should lead to patients been seen and managed in a more timely way by medical teams. It should also result in more efficient treatment pathways and a shortened length of patient stay.

Consultant staff across UHL were supported by NCHDs at registrar, SHO and intern grades providing 24/7 medical cover. UHL had an approved funding for a total of 513 WTE NCHDs — 227 WTE registrars, 212 WTE SHOs and 74 WTE interns. This number included an uplift of an additional 28 NCHDs at registrar and SHO grades. At the time of this inspection, 7% of the approved and funded NCHD's positions in UHL were unfilled.

Health and social care professional workforce

Similar to other hospitals inspected as part of the HIQA's current monitoring programme, the filling of pharmacist's positions at UHL was challenging for hospital management. UHL had an approved funding for 75 WTE pharmacists, but 32% (24 WTE) of these positions were unfilled. UHL also had a shortfall of 25% (11 WTE) between the approved and funded, and actual number of pharmacy technicians in position. This shortfall in pharmacy staff did impact on care delivery across all clinical areas visited during this inspection.

Hospital management also experienced challenges in filling the following health and social care professionals positions in UHL:

- 42% of the approved and funded physiotherapist's positions were unfilled
- 24% of the approved and funded occupational therapist's positions were unfilled

- 35% of the approved and funded medical social worker's positions were unfilled
- 7.5% of the approved and funded dietician's positions were unfilled.

Health and social care professionals are key members of the multidisciplinary team that are the cornerstone of the OPTIMEND service in UHL's emergency department, and are frontline senior decision-makers for progressing the care of older people attending the department. Therefore, the unfilled positions across these professionals in UHL had the potential to impact the effective functioning of that service among others.

Nursing workforce

UHL had approved funding for a total of 1,561.52 WTE nurses (inclusive of management and other grades). This number was inclusive of the additional nursing staff approved under the *Framework for Safe Nurse Staffing and Skill Mix in Adult Emergency Care Settings in Ireland* and *Framework for Safe Nurse Staffing and Skill Mix in General and Specialist Medical and Surgical Care Settings in Ireland.* Three quarters (75%) of the approved and funded nursing staff positions were filled at time of this inspection. Hospital management were trying to fill the remaining 25% vacant positions through a continual, recruitment campaign and agency staff. Shortfalls between the approved and funded, and actual filled nursing staff positions (including management grades) were evident across the three inpatient clinical areas visited during this inspection.

Nursing staff were supported by healthcare assistants. The hospital was approved and funded for 280 WTE healthcare assistants. During this inspection, there was a shortfall (range 21% to 36%) in the number of approved and funded, and actual healthcare assistants in position in the three inpatient clinical areas visited during this inspection.

Staff were not measuring the proportion of care delayed, unfinished or omitted as a consequence of the shortfall between the approved and funded, and actual filled nursing and healthcare assistant staff positions. Therefore, it was difficult to quantify the specific impact that the staffing shortfalls had on care delivered in the inpatient clinical areas visited during this inspection.

In 2022, the hospital's staff absenteeism rate was 9.4% (excluding COVID-19), which was significantly higher that the HSE's target of 4% and the highest of all Model 4 hospitals that year. The staff absenteeism rate had decreased in February 2023 to 5.9% (5.5% non COVID-19 and 0.4% COVID-19) and there was an improvement on the 12.25% rate (including COVID-19 related absence) in January 2022. However, hospital management and directorate management teams should continue to review the rate and reasons for staff absenteeism at UHL. UHL had occupational services and Employee Assistance Programmes available for staff, and ULHG had resourced and supported the establishment of a health and wellbeing centre for staff.

Staff uptake of essential and mandatory training

The hospital had an approved funding for a total of 18.23 WTE clinical skills facilitators to support clinical staff to maintain and further develop their clinical skills across all clinical areas. However, similar to other staff grades, at the time of this inspection, there a 20% shortfall in the approved and actual number of clinical skills facilitators in position at UHL.

There was evidence that CNMs and clinical skills facilitators were responsible for the recording and oversight of the uptake of mandatory and essential staff training for their area of responsibility. Staff were required to complete mandatory and essential training in infection prevention and control, medication safety and INEWS on the HSE's online learning and training portal (HSELanD). Attendance at essential and mandatory training by NCHDs was recorded on the National Employment Record (NER) system.§§§§§§§§§ Nursing, medical and support staff who spoke with inspectors confirmed that they had received formal induction training on commencement of employment in UHL.

It was evident from staff training records reviewed by inspectors that staff undertook multidisciplinary team training appropriate to their scope of practice at a minimum every two years. Staff training records from the inpatient clinical areas visited showed that the uptake of essential and mandatory training in basic life support, the early warning system, hand hygiene and sepsis management was sub-optimal and should be an area of focused improvement following this inspection.

Overall, while this inspection identified ongoing work to seek to fully staff various departments in UHL, deficits of staff across key healthcare professionals was found compared to agreed complements. Service safety was therefore being maintained through an added burden of responsibility and workload for pre-existing staff alongside some deficits in service delivery. This is a far from ideal situation that hospital management were aware of and working to address. Hospital management, like other hospitals were challenged in their efforts to recruit staff across the professions. Notwithstanding this, hospital management need to ensure that there are sufficient staff available at the right time, with the right skills to deliver safe, high-quality care and that there are contingencies in place to ensure that the service can meet increase in demand for unscheduled and emergency care. It is also essential that hospital management ensure that all clinical staff have undertaken mandatory and essential training appropriate to their scope of practice and at the required frequency, in line with national standards.

Judgment: Partially compliant

§§§§§§§§§ The National Employment Record is a national system for recording non-consultant hospital doctor paperwork, including evidence of training. The system was designed to minimise repetitive paperwork requirements for non-consultant hospital doctors and eliminate duplication when rotating between employers.

Quality and Safety Dimension

Inspection findings in relation to the quality and safety dimension are presented under seven national standards (1.6, 1.7, 1.8, 2.7, 2.8, 3.1 and 3.3) from the three themes of person-centred care and support, effective care and support, and safe care and support. Key inspection findings leading to the judgment of compliance with these nationals standards are described in the following sections.

Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.

Inspectors observed how staff in the inpatient clinical areas visited during this inspection promoted a person-centred approach to care and were observed by inspectors to be respectful, kind and caring towards patients, and being responsive to patient's individual needs. In general, the physical environment in the three inpatient clinical areas visited promoted the privacy, dignity and confidentiality of patients receiving care. These findings were consistent with the overall findings from the 2022 NIES, where most participants who completed the survey felt they were treated with respect and dignity, and had enough privacy while receiving care in UHL.

Inspectors observed that in general, patient's information was protected and stored appropriately. Whiteboards were used to record activity in the clinical areas visited and relevant clinical information. Personal identifiable information was generally not recorded on the whiteboards. However, in one clinical area visited, patient names were identifiable, which was a potential breach of general data protection regulations. This was brought to the attention of the CNM2 for immediate remedy.

Overall, there were examples of privacy, dignity and autonomy being promoted in the three inpatient clinical areas visited during this inspection. Staff were aware of the need to respect and promote the dignity, privacy and autonomy of people receiving care at UHL and this is consistent with the human rights-based approach to care promoted by HIQA. It is important that patients' personal information is protected at all times. Hospital management needs to ensure that systems and processes are in place to ensure compliance with relevant data protection legislation.

Judgment: Substantially compliant

Standard 1.7: Service providers promote a culture of kindness, consideration and respect.

Inspectors were satisfied that hospital management and staff promoted a culture of kindness, consideration and respect for people accessing and receiving care in all the clinical areas visited. Inspectors observed staff to be respectful, kind and caring towards patients in all the clinical areas visited. Staff were observed actively listening to and communicating with

patients in an open and sensitive manner, in line with the patient's expressed needs and preferences. Staff were also observed responding in a timely manner to patients and were attentive to patient's individual needs. This was confirmed by patients who spoke positively about their interactions with staff. A culture of kindness, consideration and respect was promoted at UHL through staff wearing name badges saying 'Hello my name is.' A number of quality improvement initiatives, such as 'what matters to you' and 'clouds over the bed', helped staff to further communicate with patients in a meaningful and person-centred way.

Judgment: Compliant

Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.

UHL had systems and processes in place to respond to complaints and concerns received from patients and or their families. All complaints received were managed in line with the HSE's complaints management policy '*Your Service Your Say*.' The complaints manager was the designated complaints officer assigned with responsibility for managing complaints and for the implementation of recommendations arising from reviews of complaints. The complaints officer managed informal and formal complaints and was supported in the role by seven WTE complaints managers. There was a complaints manager assigned to each clinical directorate. Each clinical directorate had oversight of the timeliness and effectiveness of the complaint management process for the clinical services in their remit. Corporate governance and oversight of the complaints management process and timeliness of responses lay with the Complaints Steering Committee and ULHG's QualSEC. UHL formally reported on the number of complaints received and rate of resolution to the HSE annually.

Inspectors were satisfied there was a coordinated response to complaints about healthcare services at UHL. Hospital management supported and encouraged point of contact complaint resolution, with complaints managed at local clinical area level by the CNM. Staff in the clinical areas visited were knowledgeable about the complaints management process. PALS managers supported and advocated for patients receiving care at UHL.

Verbal complaints were not being tracked and trended at UHL at the time of this inspection, this is a missed opportunity for shared learning and quality improvement. UHL formally reported on the number, type and themes of complaints received annually. Hospital management received 700 complaints in 2022, with the biggest proportion of these complaints related to the medical directorate. 52% of the complaints received by the medical directorate related to the emergency department. 70% of the complaints received in 2022 were resolved within the 30-day timeframe set by the HSE, which was marginally lower than the HSE'S target of 75%. The majority of complaints (38%) managed in 2022 were related to the theme of safe and effective care, 25% were related to communication and 18% were related to access. Staff confirmed that they received feedback on complaints, generally this was from the CNM during shift handover or multidisciplinary safety huddles.

UHL assessed compliance with the recommendations from 'Learning to Get Better' report published by the Ombudsman********** and quality improvement plans were developed to address any areas of non-compliance. There was also evidence that quality improvement initiatives were introduced in UHL to improve services as a result of complaints received. For example, hospital management worked with Autism Ireland to develop an autism friendly environment in the emergency department. An electronic information board was also installed in the emergency department informing attendees to the department how long they would be waiting to be triaged and medically reviewed. It also provided information on waiting times in the local minor injury units. Each clinical directorate were responsible for the implementation of all quality improvement initiatives within the clinical services in their remit.

Patients who spoke with inspectors in the clinical areas visited had not received information on the hospital's complaints process or on how to access independent advocacy services. Patients said they would speak to a nurse or the CNM if they had any complaints. Inspectors did not see information on how to access independent advocacy services displayed in any of the clinical areas visited during this inspection. This is something that can be easily remedied following inspection.

Overall, HIQA was assured that the hospital had effective and robust systems and processes in place to respond promptly, openly and effectively to complaints and concerns raised by people using the service. Patients receiving care at UHL should be provided with information on the UHL's complaints process and on how to access independent advocacy services. Hospital management should continue to monitor the timeliness of complaint resolutions and should ensure that the hospital comes into full compliance with the HSE's target of 75% of complaints being resolved within a 30-day timeframe.

Judgment: Substantially complaint

Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high-quality, safe, reliable care and protects the health and welfare of service users.

Inspectors found the physical environment of all the clinical areas visited during this inspection was generally well maintained and clean with few exceptions. There was evidence of general wear and tear of woodwork and floor surfaces, with paintwork and wood finishes chipped, which did not facilitate effective cleaning and posed an infection prevention and control risk. This finding was consistent with the 2022 NIES findings, where UHL scored 8.9, slightly lower than the national average (9.0) in the question related to the cleanliness of the hospital room or ward.

CNMs who spoke with inspectors were satisfied with the level of cleaning resources and maintenance services during and outside core working hours. Environmental cleaning was

********** Learning to Get Better Report. 2015. Available online from: https://www.ombudsman.ie/publications/reports/learning-to-get-better/Learning-to-Get-Better.pdf

carried out by an external contract cleaning company with onsite presence 24/7. Cleaning supervisors and CNMs had oversight of the standard of cleaning and daily cleaning schedules in their areas of responsibility. Discharge and terminal cleaning was carried out by designated cleaning staff. Cleaning staff who spoke with inspectors demonstrated their knowledge on environmental and equipment hygiene. Inspectors observed appropriate segregation of clean and used linen. Used linen was stored appropriately.

Cleaning of patient equipment was assigned to healthcare assistants with oversight by the CNM2. All clinical areas visited during this inspection used a green tagging system to guide and identify equipment that was clean. Hazardous material and waste was stored safely and securely. While supplies and equipment were stored adequately and appropriately, storage was an issue in all the clinical areas visited during this inspection.

Inspectors observed signage regarding hand hygiene clearly displayed, strategically located and readily available in all clinical areas visited. Infection prevention and control signage in relation to transmission-based precautions was also observed. Wall-mounted alcohol-based hand sanitiser dispensers and personal protective equipment (PPE) were also readily available. Inspectors observed staff in the clinical areas wearing appropriate PPE in line with public health guidelines in place at the time of this inspection. Hand hygiene sinks in the clinical areas inspected conformed to requirements.[††††††††††]

Physical distancing was observed to be generally maintained between beds in multi-occupancy rooms in the inpatient clinical areas visited. However, adequate physical distancing was a challenge in the large 'nightingale' multi-occupancy rooms.

There were processes in place to prioritise and ensure appropriate placement and management of patients with suspected or confirmed communicable disease, which was underpinned by a formalised prioritisation criteria, with oversight by UHL's infection prevention and control team. At the time of this inspection, a new 96-bed block was under construction and hospital management told inspectors that it is intended that 48 of these beds were replacement beds that when operational will increase the number of isolation facilities in UHL. Notwithstanding this, the number of isolation rooms with adequate en-suite bathroom facilities was insufficient for a Model 4 hospital. When no isolation facilities were available, patients requiring transmission-based precautions were cohorted in a multi-occupancy room, which was in keeping with national guidance. During inspection, in one of the clinical areas visited, inspectors observed that the door to the room where patients were cohorting was open, which is not in line with effective infection prevention and control practices. This was brought to the attention of the CNM for immediate remedy.

In summary, the physical environment and patient equipment was observed to be generally clean and well maintained. However, HIQA was not fully assured that at the time of this inspection the physical environment supported the delivery of high-quality, safe, reliable care

[††††††††††] Department of Health, United Kingdom. *Health Building Note 00-10 Part C: Sanitary Assemblies*. United Kingdom: Department of Health. 2013. Available online from: https://www.england.nhs.uk/wp-content/uploads/2021/05/HBN_00-10_Part_C_Final.pdf.

and protected the health and welfare of people receiving care therein. There were limited isolation facilities in the hospital and the shortfall in these facilities will not be addressed under current plans until such time as the new bed block is built and operational in late 2024. Adequate physical distancing between beds in 'nightingale' wards was difficult to maintain. Doors of rooms were left open where patients requiring transmission-based precautions were cohorted, which is not consistent with effective infection prevention and control practices. Inadequate storage facilities was an issue in all clinical areas visited. Collectively, these issues presented a potential risk to patient safety on the day of inspection.

Judgment: Non-compliant

Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.

There were systems and processes in place at UHL to monitor, analyse, evaluate and respond to information from a variety of sources in order to inform continuous improvement of services. Sources included; quality and safety performance metrics, findings from audit activity, risk assessments, quality nursing and midwifery metrics, patient-safety incident reviews, complaints and NIES. National performance indicators and benchmarks were used by hospital management to measure the quality and safety of healthcare services provided at UHL.

Infection prevention and control monitoring

HIQA was satisfied that the IPCC had oversight of and actively monitored the effectiveness of infection prevention and control practices at UHL. Hospital management monitored and regularly reviewed performance indicators in relation to the prevention and control of healthcare-acquired infection.[‡‡‡‡‡‡‡‡‡‡‡] Every month UHL monitored and publically reported on rates of:

- *Clostridioides difficile* infection
- CPE
- hospital-acquired *Staphylococcus aureus* blood stream infections
- hospital-acquired COVID-19 and outbreaks.

In 2022, the hospital's rate of new cases of:

- hospital-associated *Clostridioides difficile* ranged from 1.20 to 7.30 new cases per month, with UHL above the HSE's target (less than 2 per 10,000 bed days) for eight of the 12 months of 2022.

[‡‡‡‡‡‡‡‡‡‡‡] Health Service Executive. *Performance Assurance Process for Key Performance Indicators for HCAI AMR in Acute Hospitals.* Dublin: Health Service Executive. 2018. Available on line from: https://www.hse.ie/eng/about/who/healthwellbeing/our-priority-programmes/hcai/resources/general/performance-assurance-process-for-kpis-for-hcai-amr-ahd.pdf.

- hospital-acquired *Staphylococcus aureus* blood stream infection ranged from 0 to 3.0 new cases, with UHL above the HSE's target (less than 0.8 per 10,000 bed days) for eight of the 12 months of 2022.
- CPE ranged from eight to 42 cases per month, with an average of 16 cases per month.

Inspectors were satisfied that the management of infection outbreaks at UHL was in line with national guidance. However, inspectors noted the difficulties that hospital management in UHL have had in managing CPE and *Clostridioides difficile* infection outbreaks. In the context of UHL's underlying infrastructure and high occupancy rates, there is a need to further enhance infection prevention and control systems and processes at the hospital.

It was evident from meetings with infection prevention and control leads and staff in clinical areas that monthly environmental, equipment and hand hygiene audits were undertaken at UHL using a consistent approach. Findings from recent environmental audits showed that all the clinical areas visited during this inspection were compliant with the national HSE target of 90% for environmental hygiene. Clinical staff confirmed that findings from environmental hygiene audits were shared with them. There was evidence that time-bound action plans, with named individuals assigned to implement identified actions, were developed when environmental and equipment hygiene standards fell below expected standards. The infection prevention control team and CNMs were responsible for implementing these action plans with executive oversight by the relevant clinical directorate and ULHG's IPCC.

Regular hand hygiene audits were conducted across a wide range of staff in UHL with oversight by the infection prevention and control team. Findings from hand hygiene audits carried out in 2022 showed that the majority of inpatient clinical areas visited during the inspection were compliant with the HSE's target of 90%. However, hand hygiene audit results for the emergency department was 87%. To improve compliance, the infection prevention and control team had provided clinical staff in the emergency department with additional training on effective hand hygiene practices. Compliance with peripheral vascular catheter and urinary catheter care bundles at UHL was also monitored monthly and documentation submitted to HIQA showed a high level of compliance with these care bundles.

Patients in UHL were screened for CPE and Methicillin-resistant *Staphylococcus aureus* (MRSA) in line with national guidance. Patients at risk of Extended Spectrum Beta-Lactamase (ESBL) producing Gram-negative bacteria and Vancomycin Resistant *Enterococci* (VRE) were screened weekly. Inspectors noted that only 70% of patients eligible for CPE screening were actually screened for the infection in 2022. To improve the rate of CPE and MRSA screening, hospital management introduced a new infection prevention and control patient screening record. This record was being trialled at the time of this inspection.

Medication safety monitoring

The MSC had oversight of the monitoring and evaluation of medication safety practices at UHL. The monitoring and evaluation of medication safety practices at UHL was limited in 2022 because the medication safety officer's position was unfilled for a large period of the year.

Nonetheless, while audit activity was limited, there was evidence that clinical–pharmacy led medication reconciliation on admission was monitored throughout the year. There was also evidence that quality improvement initiatives were introduced to improve medication safety practices at the hospital. These initiatives included the trialling of a new medication record and a new subcutaneous insulin record, with the intention of rolling out both records in 2023. The new records were rolled out for use across the hospital the week before HIQA's inspection. Inspectors did see the two records in use in the inpatient clinical areas visited. There was evidence that findings of audit activity into medication practices were shared with staff. Inspectors saw learning notices related to *Staphylococcus aureus Bacteraemia* that was circulated to staff. Auditing of medication practices is essential to ensure that medication safety practices in UHL are in line with best practice standards and guidance.

Antimicrobial stewardship monitoring

At the time of this inspection, the deficit in pharmacist staffing at UHL impacted on the proactive monitoring of antimicrobial use at the hospital. The pharmacy department had implemented mitigating measures to reduce the potential risk to patient safety. These included the conduct of regular rounds in clinical areas to review antimicrobial consumption and the weekly auditing of meropenem[§§§§§§§§§§] use.

Deteriorating patient monitoring

ULHG's DPSC had oversight of UHL's compliance with national guidance on INEWS version 2 and clinical handover. Performance data relating to the escalation protocol for the deteriorating patient was collated monthly through the HSE's 'Test Your Care'[**********] metrics. UHL also participated in the national pilot deteriorating audit in 2022. Overall, apart from 'Test You Care' metrics, there was limited evidence in the documentation reviewed by inspectors that compliance with national guidance on INEWS and sepsis management was regularly audited at UHL. This is something easily remedied following this inspection.

Transitions of care monitoring

The number of new attendances to UHL's emergency department, PETs, number of persons who leave the emergency department without completion of treatment, ALOS of medical and surgical inpatients, DTOC and ambulance turnaround times were tracked at UHL every month. There was evidence that compliance with the use of the $ISBAR_3$ communication tool for clinical handover was audited across UHL. There was also evidence that time-bound action plans were developed with named individuals assigned with responsibility for the implementation of actions so as to bring UHL into full compliance with national guidance on clinical handover.

[§§§§§§§§§§] Meropenem is an ultra-broad spectrum antibiotic, which should be reserved for use under specialist supervision for serious infections which are resistant to more conventional antibiotics.
[**********] Performance metrics that measure, monitor and track the fundamentals of nursing and midwifery clinical care processes.

Staff in all three clinical areas visited were not aware of the hospital's findings from the NIES and could not provide examples of quality improvement plans introduced to improve the experience for people using the healthcare services in UHL. This is something that can be addressed following this inspection.

Overall, HIQA was not fully assured that all information from monitoring activities was being used to improve practices in relation to the medication safety practices, deteriorating patient and the transitions of care, and the effectiveness of any improvements were being re-audited at UHL. Auditing of medication of safety practices and compliance with national guidance on INEWS and sepsis management could be strengthened and improved. Auditing of clinical practice is essential to ensure that care and services provided at UHL are in line with best practice standards and guidance, and that all areas for improvement are identified. Audits also provide hospital management and people who use the service with assurances on the quality and safety of clinical services provided at UHL. There is also a need to further enhance infection prevention and control systems and processes at UHL to manage infection outbreaks in the short to medium-term.

Judgment: Partially compliant

Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.

There were arrangements in place at UHL to proactively identify, analyse, evaluate and manage immediate and potential risks to people availing of healthcare services at UHL. Risk and patient safety advisors were assigned to each clinical directorate. There was sufficient evidence from documentation reviewed by inspectors and from staff representatives who spoke with inspectors that the management of identified risks at UHL were in line with the HSE's integrated risk management policy.

It was evident from documentation reviewed and meetings with staff that risks identified at local clinical area level were recorded on local risk registers, corrective actions and controls were identified by CNMs and applied to mitigate any potential and actual risk to the quality and safety of clinical services. CNMs were responsible for monitoring the effectiveness of those actions and controls in their areas of responsibility. More serious risks were escalated to the respective clinical directorate's SIMT and recorded on the clinical directorate's risk register. High-rated risks not managed at clinical directorate level were escalated to ULHG's EMT and recorded on UHL's corporate risk register. At the time of this inspection, nine high-rated risks related to the four areas of known harm were recorded on UHL's corporate risk register. These included risks related to: infrastructure and physical environment, staffing, pharmacy services, hospital-acquired infections, overcrowding in the emergency department, clinical handover and the procurement of supplies following Brexit. It was evident that the corporate risk register was reviewed and corrective measures were updated regularly. However, that was not the case for local risk registers. The majority of local risk registers reviewed by inspectors had measures that were overdue for review, with some review dates

dating back to quarter four of 2021. Also, the local risk registers did not always have a named individual assigned with the responsibility to implement the corrective measures or that actions were time-bound. This was not in line with effective risk management processes.

Infection screening and outbreak management

Patients were screened for multi-drug resistant organisms and patients who were suspected or symptomatic for COVID-19 were screened at point of entry to the hospital as per the national guidance at the time of this inspection. Not all patients were screened on admission for CPE, as per national guidance. Due to the limited number of single isolation rooms at UHL, all patients requiring transmission-based precautions were not isolated within 24 hours of admission or diagnosis as per national guidance. Potential risks were mitigated by the cohorting of patients requiring transmission-based infection in multi-occupancy rooms or the boarding of patients in single cubicles in the emergency department, if patients had accessed care there. This had implications for patient flow in the emergency department.

In 2022, the hospital had a number of infection outbreaks in Burholderia,[††††††††††] CPE, *Clostridioides difficile*, *Staphylococcus aureus Bacteraemia,* COVID-19 and influenza. HIQA was satisfied that the management of these infection outbreaks was in keeping with national guidance and the process was underpinned by a formalised up-to-date policy. Multidisciplinary outbreak teams were convened to advise and oversee the management of the infection outbreaks. Summary reports from these infection outbreaks, reviewed by inspectors were comprehensive and outlined control measures to mitigate the risk to patient safety in the short-term, potential contributing factors and recommendations to reduce reoccurrence.

Medication safety

UHL did not have a comprehensive clinical pharmacy service. Pharmacy-led medication reconciliation was done on admission. Medication stock control was carried out by pharmacy technicians every week in all clinical areas visited during this inspection. HIQA was satisfied that risk-reduction strategies for high-risk medicines were used in UHL. The hospital had a list of high-risk medications aligned with the acronym 'A PINCH'.[‡‡‡‡‡‡‡‡‡‡‡] UHL had a list of sound-alike look-alike medications (SALADs). Inspectors observed the use of risk-reduction strategies to support the safe use of high-risk medicines in the clinical areas visited. Prescribing guidelines, including antimicrobial guidelines and medication information were available and accessible to staff at the point of care. The shortfall in pharmacy staff significantly impacted on the ability to provide a comprehensive clinical pharmacy service, which included a clinical pharmacist-led medication reconciliation service for all clinical areas in UHL. Accepting the current deficits, management at UHL should consider approaches to

[††††††††††] Burkholderia cepacia is a group of bacteria found in soil and water. It can cause serious respiratory infections in patients who are susceptible to illness.

[‡‡‡‡‡‡‡‡‡‡‡] Medications represented by the acronym 'A PINCH' include anti-infective agents, anti-psychotics, potassium, insulin, narcotics and sedative agents, chemotherapy and heparin and other anticoagulants.

utilise existing pharmacy staff to address key areas for improvement identified through the medication safety programme.

Deteriorating patient

UHL had implemented the INEWS version 2 guideline and observation chart. Staff in the clinical areas visited were knowledgeable about the INEWS escalation process for the deteriorating patient. Systems were in place to manage patients with a triggering early warning system. Staff reported that there was no difficulty accessing medical staff to review a patient whose clinical condition was deteriorating. The $ISBAR_3$ communication tool was used when requesting a patient review. UHL's outreach critical care team were available to review patients with a triggering early warning score. Inspectors reviewed a sample of healthcare records and found that the grade of NCHD who reviewed patients with a triggering early warning score was not in line with the national escalation protocol. Inspectors discussed this issue with the CNM on the day of inspection.

Safe transitions of care

UHL had some systems in place to reduce the risk of harm associated with the process of patient transfer in and between healthcare services, and to support safe and effective discharge planning. UHL had a team of patient flow coordinators and staff used a number of transfer and discharge forms to support the exchange of information during the transfer process, which is imperative to the safe transition of care. Notwithstanding this, the sample of healthcare records reviewed by inspectors showed a delay in the issuing of discharge summaries to primary healthcare services. Timely discharge summaries to primary care healthcare professionals are essential to enable and support improved quality and continuity of care after discharge from acute healthcare services.

Policies, procedures and guidelines

UHL had a suite of up-to-date infection prevention and control policies, procedures, protocols and guidelines, which included policies on standard and transmission-based precautions, outbreak management, managements of patients in isolation and equipment decontamination. UHL also had a suite of up-to-date medication policies, procedures, protocols and guidelines. All policies, procedures, protocols and guidelines were accessible to staff via the hospital's computerised document management system.

In summary, HIQA was satisfied that in general there were systems and processes in place at UHL to proactively identify and manage the potential risks associated with the four areas of known harm. However, there was scope for improvement in some areas. All risk registers should be reviewed regularly to ensure that corrective actions and controls are effective in mitigating the potential and actual risks to patient safety. A comprehensive clinical pharmacy service, inclusive of pharmacy-led medication reconciliation should be developed and implemented across all clinical areas to support safe medication practices at UHL.

Judgment: Substantially compliant

Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.
There were systems in place at UHL to identify, report, manage and respond to patient-safety incidents in line with national legislation, policy and guidelines. The management of patient-safety incidents was underpinned by a formal policy. Patient-safety incidents were reported on the hospital's computerised document management system and NIMS. Each clinical directorate's SIMT had oversight of the management of category one incidents that occurred in the clinical services within their remit. At corporate governance level, ULHG's QualSEC and ULHG's EMT had oversight of the numbers and categories of reported patient-safety incidents that occur at UHL. A total of 7,033 patient-safety incidents were reported in 2022 across ULHG, which represented an increase of 16% on the number of incidents reported in 2021. UHL's rate of reporting of clinical incidents§§§§§§§§§§ to NIMS for 2022 ranged from 17.70 to 25.50 per month (average 21.7 incidents per month), which is higher than any other Model 4 hospital that year. Higher reporting rates of clinical incidents generally suggest there is a good reporting culture and greater visibility of risk at UHL, which are key determinants for safer healthcare services. In 2022, all clinical incidents reported were uploaded to NIMS within 30 days of date of notification. Staff who spoke with HIQA were knowledgeable about what and how to report, manage and respond to a patient-safety incident. Staff were aware of the most common patient-safety incidents reported at UHL — slips, trips or falls. The risk and patient safety department tracked and trended patient-safety incidents in relation to the four key areas of known harm at local clinical area and wider hospital levels. Information relating to and feedback on patient-safety incidents was shared with staff in clinical areas by CNMs at clinical handover and multidisciplinary safety huddles. Multidisciplinary safety huddles also enabled discussions on operational issues that could impact on patient safety. These huddles were held in all clinical areas visited and the effectiveness of the huddles was audited. HIQA was satisfied that there was oversight and monitoring of the implementation of recommendations from reviews of patient-safety incidents at individual clinical directorate level and by the hospital's risk and patient safety department. Updates on the progress of implementation of recommendations were provided as part of each clinical directorate's quarterly update to ULHG's QualSEC. Notwithstanding this, it was found that only approximately 30% of external reviews commissioned on foot of serious reportable events were completed within the 125 day timeframe set out in the HSE's Incident Management Framework.

§§§§§§§§§§ A clinical incident is a subset of patient-safety incidents, it's an event or circumstance which could have, or did lead to unintended and or unnecessary harm.

Infection prevention and control patient-safety incidents

UHL's infection prevention and control team reviewed all infection prevention and control related patient-safety incidents and made recommendations for corrective action or preventative measures. Clinical directorates and ULHG's IPCC had oversight of the implementation and effectiveness of any actions and measures introduced to mitigate any infection related patient safety risk.

Medication patient-safety incidents

Medication patient-safety incidents were categorised according to the severity of outcome as per the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) medication error categorisation. Medication related patient-safety incidents were reported monthly by UHL's medication safety officer to the MSC and ULHG's DT&C. In 2022, 312 medication patient-safety incidents were reported at UHL.

Patient-safety incidents in relation to the deteriorating patient or safe transitions of care were not tracked or trended at the hospital.

Overall, HIQA was satisfied there was an effective system in place in UHL to identify, report, manage and respond to patient-safety incidents in relation to the four key areas of known harm. Infection prevention and control patient-safety incidents and medication incidents, were tracked and trended, and it was evident that some initiatives were implemented to improve clinical practices and patient safety in these areas. Nonetheless, it is imperative that hospital management work to bring UHL into compliance with the 125 days' timeframe for completion of external reviews commissioned following a serious reportable event and or serious incident in UHL.

Judgment: Substantially compliant

Conclusion

Since HIQA's last inspection of UHL's emergency department, hospital management have received substantial supports and resources to strengthen and improve operational effectiveness and efficiencies in the emergency department, at wider UHL level, and to further strengthen and enhance integration and collaboration with MWCH. HIQA carried out a two-day unannounced inspection of UHL to assess compliance with 11 national standards from the *National Standards for Safer Better Health*. The inspection focused on four areas of known harm — infection prevention and control, medication safety, deteriorating patient and transitions of care. Inspectors also assessed the effectiveness of the short and medium-term measures introduced to improve operational effectiveness, patient flow and inpatient capacity at UHL, across ULHG and MWCH following HIQA's last inspection in March 2022. Such an assessment was conducted in the full awareness that underlying bed capacity deficits continue to exist at UHL, and that these will not be addressed for a significant period of time until much needed planned additional bed capacity is provided at UHL and wider ULHG level.

Capacity and Capability

UHL had formalised and integrated corporate and clinical governance arrangements in place for assuring the delivery of high-quality, safe and reliable healthcare, but there was scope for improvement to ensure that all governance committees function as intended. Actions arising from meetings of all committees should be time-bound, assigned to individuals, implemented and the progress of implementation monitored frequently. Terms of reference of governance committees should be reviewed and updated at regular intervals to ensure the purpose and scope of all committees remain appropriate, relevant and functional so as to support and improve operational and clinical effectiveness at UHL.

UHL had management arrangements in place to support and promote the delivery of healthcare services with defined lines of responsibility and accountability, However, despite the initiatives introduced as a result of increased support and resourcing, efforts to further enhance managerial efficiencies at UHL remains a work in progress. While there was some evidence of enhanced operational efficiencies in UHL's emergency department, the substantive issue of inpatient capacity at UHL remained and this affected patient flow and contributed to the overcrowding observed in the emergency department during this inspection.

Since March 2022, UHL have had a significant increase in the number of medical, nursing and administrative staff. Hospital management at UHL, like their counterparts in other hospitals were challenged in their efforts to recruit clinical staff across the health professions, but were successful in their efforts to recruit the additional approved and funded complement of consultants in emergency medicine, NCHDs and patient flow coordinators. Nonetheless, at the time of this inspection, there was a continued substantive shortfall between UHL's approved and funded, and actual complement of medical, nursing, pharmacy staff, and health and social care professionals. Hospital management need to ensure that there are staffing contingencies in place to ensure that UHL can meet service requirements and demand for the

Midwest region. Recruitment of clinical staff across professions is a system-wide challenge impacting on care delivery, therefore it is essential that hospital managers are supported and enabled by national HSE in their efforts to ensure there are sufficient staff available at the right time, with the right skills to deliver safe, high-quality care at UHL. Hospital management should also ensure that all clinical staff in UHL have undertaken mandatory and essential training appropriate to their scope of practice and at the required frequency, in line with national standards.

Quality and Safety

It was evident that a culture of kindness, consideration and respect was actively promoted by all staff in the clinical areas visited during this inspection. Staff were observed to be kind, caring and respectful towards patients. The privacy, dignity and confidentiality of patients receiving care in the inpatient clinical areas visited during this inspection was promoted. However, this was not the case for patients receiving care in the emergency department. Delivering care in an overcrowded emergency department did not support or enable the delivery of safe, person-centred care and negatively impacted on any meaningful promotion of patients' human rights.

HIQA was assured that UHL had systems and processes in place to respond promptly, openly and effectively to complaints and concerns raised by people using the healthcare services at the hospital. Nonetheless, hospital management should ensure that UHL comes into full compliance with the HSE's target of 75% of complaints being resolved within a 30-day timeframe. Patients should also be provided with information on the hospital's complaints process and on how to access independent advocacy services.

The clinical areas visited during this inspection were found to be clean and well maintained, but HIQA was not fully assured that the physical environment supported the delivery of high-quality care or protected the health and welfare of people. In particular, the 'nightingale wards' visited on inspection were particularly cramped and not in keeping with modern standards of inpatient hospital accommodation.

UHL had systems in place to monitor, evaluate and continuously improve healthcare services, but inspectors were not fully assured that all information from monitoring activities was being used efficiently to improve clinical practices in relation to the four areas of known harm. Auditing of clinical practice at UHL is an area that could be strengthened and improved. Auditing is essential to ensure that care and services provided in UHL are in line with best practice standards and guidance, that areas for improvement are identified and that hospital management and people who use healthcare services in UHL are provided with assurances on the quality and safety of the services provided at the hospital.

UHL had a system in place to identify, report, manage and respond to patient-safety incidents in relation to the four key areas of known harm, with effective oversight from relevant governance structures. Nonetheless, improvements are required to bring UHL into compliance

with the timeframe for completion of external reviews commissioned following a serious reportable event and or serious incident.

There were systems and processes in place at UHL, with effective oversight from appropriate governance arrangements, to manage any potential and actual risks of harm to people using healthcare services at UHL. However, inspectors were not fully satisfied that the arrangements in place to manage risks in relation to the emergency department were effective in mitigating the risks to patient safety identified during this inspection. Inspectors were also concerned that the short and medium-term measures applied to mitigate the risks arising from the overcrowding and lengthy waiting times in UHL's emergency department identified in HIQA's previous inspection, had a limited impact on resolving the issue of overcrowding in the department.

Similar to previous inspection findings, UHL was working at 105% capacity and the volume of people attending UHL's emergency department was consistently in the range of 250 attendees per day. Consequently, the emergency department was not functioning as effectively and efficiently as it should be. It was overcrowded and the significant issues with patient flow and inadequate inpatient capacity identified previously by HIQA remained, which collectively continued to pose a patient safety risk. The issue was further compounded by the AMU and ASAU not functioning as they should. Moreover, while a perceived inadequate level of resourcing and access to general practice in the Midwest region were cited by some HSE managers to HIQA as a likely key causal factor in the very high ongoing presentation rates to UHL's emergency department, there also appeared to be a lack of certainty as to what the underlying additional need for such services is, nor was there a calculated plan to seek to address this deficit. Furthermore, while HIQA was able to clearly identify a number of new initiatives that have been introduced to enhance community care pathways for some patients and to encourage more seamless integration of care in the region between UHL and community services, these initiatives were new and had yet to fully embed. The potential for meaningful gain in patient flow and inpatient capacity at UHL could be greater, but this is dependent both on more push from the acute services in UHL and pull from the community services in MWCH. It was not clear to HIQA what the quantified full yield of benefit was expected from such initiatives in providing alternate much needed capacity as part of a planned overall full healthcare system response to the emergency department overcrowding challenge in UHL. Furthermore, while the rate of admission of patients from UHL's emergency department was comparable to other Model 4 hospitals at 24%, unscheduled and emergency care accounted for 72% of the total admissions at UHL in 2022. This had significant implications and risks for scheduled care activity at UHL and for patients waiting to have planned care and treatment.

After HIQA's last inspection, UHL's escalation plan and processes were revised. The revised processes were fully introduced across UHL three weeks before HIQA's most recent inspection. Since the introduction of these revised processes, there was some evidence of an improvement in the waiting times for patients attending UHL's emergency department in the areas of triage and medical review. Notwithstanding this, patients attending UHL's emergency

department continue to be exposed to a higher level of risk while waiting in the department for an inpatient bed in the main hospital. This remained a concern for HIQA because of the association of prolonged waiting times in the emergency department with increased morbidity and mortality.

HIQA acknowledges that the revised processes and support measures introduced at UHL, ULHG and MWCH levels over the past 11 months need time to embed. Improvements to date have focused on patient flow and efforts to improve operational efficiency and resourcing in UHL. Some success has been achieved, and this is recognised in this report through an improvement in levels of compliance rating achieved across a number of the national standards assessed in UHL's emergency department in February 2023 when compared to March 2022. However, significant risks to patient safety remain. If the underlying issue of ineffective patient flow and inpatient capacity at UHL is to be meaningfully addressed, then more needs to be done to incorporate regional measures in the community sector and better utilisation of community services. This will require a concerted, consolidated plan involving both the acute and community sectors.

While the addition of the new 96-bed block is urgently needed at UHL, the recently commissioned patient flow analysis identified that 302 new additional beds are potentially required to meet the projected future population need of the Midwest region. Therefore, further capital investment beyond these 96 beds may be needed at UHL and within the wider Midwest region. Given the challenges with staff recruitment experienced at UHL, due diligence and consideration will also be needed when considering and planning how the new capacity will be deployed and staffed to ensure that the additional capacity provides the benefits needed for UHL. In the meanwhile, any other measures that could be deployed to add inpatient capacity at UHL should be considered and acted on. This includes consideration of procuring facilities and services from the private sector, which could yield some meaningful interim gains in the short to medium-term.

Furthermore, HIQA notes that as part of current plans in place relating to the addition of the new 96-bed block, it is intended that 48 beds from the old block of inpatient accommodation will be retired. This inspection has further reiterated the lack of suitability of this older bed stock as currently configured. However, and recognising that the addition of only 48 extra beds to the hospital bed stock may not fully mitigate risks posed by overcrowding in the emergency department, careful consideration of the balance of competing risks needs to be considered as part of decision-making in this wider context. Indeed, there may be potential with some additional minor capital expenditure for at least some of this pre-existing bed stock to be used in a safer way than currently enabled to provide much needed additional capacity in the context of serious risks posed by an ongoing overcrowded emergency department. Moreover, such capacity would be realised much more quickly than through building further new bed blocks.

Significant efforts and investment has occurred at UHL – with external input – to seek to address staffing deficits and improve operational efficiencies to enhance the flow of patients through UHL since HIQA's last inspection in March 2022. There have been much needed and

welcome developments that by the admission of hospital management and HSE remain a work in progress. However, overcrowding at UHL's emergency department remains a persistent problem, which will not be fully addressed until the key elements of additional capacity, further enhanced operational efficiency and more seamless integration of care across acute, community and general practice services within the Midwest region are maximised to their potential to fully meet the growing population demand and needs.

To build on the work that has been progressed to date, UHL and the Midwest region need an integrated action plan to ensure a much broader approach to service investment and reform in the Midwest region, aligned to the ideals of Slaintecare. Such a concerted plan needs to be rapidly developed-focusing on actions with measureable, sustainable outcomes related to service configuration, capacity, resourcing and further integration of both the acute and community sectors. This will require a commitment from the HSE to rolling out further innovative, alternative approaches to the delivery of care across the Midwest region so that operational effectiveness and efficiencies are gained and sustained at UHL. This should include enhancing primary care services so that real alternatives are made available to people who may not require emergency and urgent care in UHL's emergency department, but need access to timely care. The enhancement of primary care services will require a determination and quantification of the number of GPs needed to adequately serve the population need and alternative service models in the Midwest region, and to enhance GP's access to diagnostics. In addition, further consideration of the utilisation of alternate pathways that can assist in avoidance of hospital admission, supported by sufficient resourcing, protocols and expansion of inclusion criteria may yield further impact and efficiencies in UHL.

Following this inspection, HIQA escalated the key inspection findings to the HSE's Chief Operations Officer, Interim National Director for Acute Operations and the National Director for Community Operations. This communication outlined the continued need for a concerted plan for the Midwest region to enhance and reform the way services are provided – inclusive of acute, community and general practice. This plan must be progressed in a timely way following this inspection to fully address the ongoing challenges that continue to be experienced by patients seeking to access services in the Midwest region. Such a plan needs to build on the good work advanced to date, allied to the addition of further bed capacity at UHL to comprehensively address ongoing risks.

Appendix 1 – Compliance classification and full list of standards considered under each dimension and theme and compliance judgment findings

Compliance classifications

An assessment of compliance with the national standards assessed during this inspection at UHL was made following a review of the evidence gathered prior to, during and after the onsite inspection at the hospital. The judgments on compliance are included in this inspection report. The level of compliance with each national standard assessed is set out here and where a partial or non-compliance with the standards was identified, a compliance plan was issued by HIQA to hospital management. In the compliance plan, hospital management set out the action(s) taken or they plan to take in order for the healthcare service to come into compliance with the national standards judged to be partial or non-compliant. It is the healthcare service provider's responsibility to ensure that it implements the action(s) in the compliance plan within the set time frames to fully comply with the national standards. HIQA will continue to monitor the hospital's progress in implementing the action(s) set out in the compliance plan (see Appendix 2).

HIQA judges the service to be **compliant, substantially compliant, partially compliant** or **non-compliant** with the standards. These are defined as follows:

Compliant: A judgment of compliant means that on the basis of this inspection, the service is in compliance with the relevant national standard.
Substantially compliant: A judgment of substantially compliant means that on the basis of this inspection, the service met most of the requirements of the relevant national standard, but some action is required to be fully compliant.
Partially compliant: A judgment of partially compliant means that on the basis of this inspection, the service met some of the requirements of the relevant national standard while other requirements were not met. These deficiencies, while not currently presenting significant risks, may present moderate risks, which could lead to significant risks for people using the service over time if not addressed.
Non-compliant: A judgment of non-compliant means that this inspection of the service has identified one or more findings, which indicate that the relevant national standard has not been met, and that this deficiency is such that it represents a significant risk to people using the service.

Capacity and Capability Dimension	
National Standard	**Judgment**
Judgments relating to overall inspection findings	
Theme 5: Leadership, Governance and Management	
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high-quality, safe and reliable healthcare.	Substantially compliant
Judgments relating to Emergency Department findings only	
Theme 5: Leadership, Governance and Management	
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high-quality, safe and reliable healthcare services.	Partially compliant
Theme 6: Workforce	
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high-quality, safe and reliable healthcare.	Partially compliant
Quality and Safety Dimension	
Theme 1: Person-Centred Care and Support	
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Non-compliant
Theme 3: Safe Care and Support	
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Partially compliant
Capacity and Capability Dimension	
Judgments relating to wider hospital and inpatient clinical areas findings only	
National Standard	**Judgment**
Theme 5: Leadership, Governance and Management	
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high-quality, safe and reliable healthcare services.	Substantially compliant
Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	Substantially compliant

Capacity and Capability Dimension	
Judgments relating to wider hospital and inpatient clinical areas findings only	
National Standard	**Judgment**
Theme 6: Workforce	
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high-quality, safe and reliable healthcare.	Partially complaint
Quality and Safety Dimension	
Theme 1: Person-Centred Care and Support	
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Substantially compliant
Standard 1.7: Service providers promote a culture of kindness, consideration and respect.	Compliant
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Substantially compliant
Theme 2: Effective Care and Support	
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Non-compliant
Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Partially compliant

Quality and Safety Dimension	
Judgments relating to wider hospital and inpatient clinical areas findings only	
National Standard	**Judgment**
Theme 3: Safe Care and Support	
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Substantially compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Substantially compliant

Appendix 2 – Compliance Plan as submitted to HIQA for University Hospital Limerick

Compliance Plan for University Hospital Limerick OSV-0001064

Inspection ID: NS_0027

Date of inspection: 21 and 22 February 2023

Introduction: This document sets out a compliance plan for healthcare providers to outline intended action(s) following an inspection by the Health Information and Quality Authority (HIQA) whereby the service was not in compliance with the National Standards for Safer Better Healthcare. Any standards that were deemed substantially compliant and require action to bring the service into full compliance can be managed locally.

This compliance plan only relates to:

- National standards that were deemed partially or non-compliant by HIQA during the inspection.

The compliance plan should be completed and authorised by the service's Chief Executive Officer, Chief Officer, designated manager and or relevant person in charge.

It is the service provider's responsibility to ensure that it implements the action(s) in the compliance plan within the set time frame(s). The compliance plan should detail how and when the service provider will comply with the standard(s) that the organisation had failed to meet.

As part of the continual monitoring to assess compliance, HIQA may ask the service provider before and during subsequent inspections to provide an update on how it is implementing its compliance plan.

Instructions for use

The service provider must complete this plan by;

- outlining how the service is going to come into compliance with the standard
- outlining timescales to return to compliance.

The service provider's compliance plan should be SMART in nature;

- Specific to the standard
- Measurable so that it can monitor progress
- Achievable
- Realistic
- Time bound.

Service Provider's responsibilities

- Service providers are advised to focus their compliance plan action(s) on the overarching systems they have in place to ensure compliance with a particular standard, under which a partial or non-compliance has been identified.
- Service providers should change their systems as necessary to bring them back into compliance rather than focusing on the specific failings identified.
- The service provider must take action within a **reasonable** time frame to come into compliance with the standards.
- It is the service provider's responsibility to ensure they implement the action(s) within the time frame(s) as set out in this compliance plan.
- Subsequent action(s) and plans for improvement related to high risks already identified to service providers should be incorporated into this compliance plan.

Continued non-compliance

Continued non-compliance resulting from a failure by a service to put in place appropriate measures to address the areas of risk previously identified by HIQA inspectors may result in escalation to the relevant accountable person in line with HIQA policy and continued monitoring.

Long-term and medium-term work to meet compliance with the standards

HIQA recognise that substantive and long-term work may be required to come into compliance with some national standards and that this may take time and require significant investment. An example of this may be in relation to non-compliance and risks identified with infrastructure. In such cases, the medium and long-term solutions should be outlined to HIQA with clear predicted timeframes as to how the service plans to improve the level of compliance with the relevant national standard.

In addition to detailing longer term solutions, HIQA requires assurance and details of;

- how mitigation of risk within the existing situation will be addressed
- information on short and medium-term mitigation measures to manage risks and improve the level of compliance with standards should be included in the compliance plan
- the long-term plans to address non-compliance with standards.

Compliance descriptors

The compliance descriptors used for judgments against standards are as follows:

Compliant: A judgment of compliant means that on the basis of this inspection, the service is in compliance with the relevant national standard.
Substantially compliant: A judgment of substantially compliant means that on the basis of this inspection, the service met most of the requirements of the relevant national standard, but some action is required to be fully compliant.
Partially compliant: A judgment of partially compliant means that on the basis of this inspection, the service met some of the requirements of the relevant national standard while other requirements were not met. These deficiencies, while not currently presenting significant risks, may present moderate risks, which could lead to significant risks for people using the service over time if not addressed.
Non-compliant: A judgment of non-compliant means that this inspection of the service has identified one or more findings, which indicate that the relevant national standard has not been met, and that this deficiency is such that it represents a significant risk to people using the service.

Compliance Plan

Compliance Plan Service Provider's Response

National Standard Judgments relating to the Emergency Department	Judgment
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high-quality, safe and reliable healthcare services.	Partially compliant

Outline how you are going to improve compliance with this standard. If significant investment and time is required to come into full compliance with this standard this should be clearly outlined including:

(a) long-term plans to come into compliance with the standard
(b) details of interim actions and measures to mitigate risks associated with partial or non-compliance with standards.

HIQA Observations

It was noted by HIQA at the time of the inspection that the AMU and ASAU were not functioning as intended to take pressure from the Emergency Department.

A full review of the AMU Model of care will be undertaken to identify all the areas that require attention to bring the service in line with the model of care envisaged the 2012 Acute Medicine Programme.

- To review the governance of the AMU & existing pathways. To develop additional pathways in conjunction with diagnostics.
- Patients will be referred directly from primary care via the bed bureau with some onward referrals from other sources including the emergency department (ED), outpatient department and other care settings, co-ordinated by the bed bureau.
- The decision regarding discharge/admission within 6 hours of patient arrival will be monitored carefully each day.
- To increase the range of dedicated same day diagnostic imaging, laboratory and other services to be in place to support assessment.
- The AMU will only admit patients for a short period for acute treatment and/or observation to its AMU beds where the estimated length of stay is less than 48 hours.
- Patients who require admission for longer than 48 hours will move from the AMU to ward 1B.

- To relocate the AMU so that it is collocated/ proximal to the ED. **Date for completion October 2023**

ASAU

A full review of the ASAU Model of care will be undertaken to identify all the areas that require attention. **Date for completion October 2023**

Governance.

New Acute Care and Emergency Directorate:
Creation of a single entity with responsibility for oversight & management with a focus on supporting staff in improving patient experience and meeting key performance indicators. A sharper focus on performance and the impact of QIPs to help drive improvements across the floor as a whole. **Date for completion September 2023**

Establishment of the Quality, Risk and Patient Safety measures within the new directorate structure (Incident/SIMT, Risk, QI initiatives) Date **for completion September 2023**

Safety huddle will continue to be a priority in the emergency department to ensure that there is a multidisciplinary approach to patient care and that there is the appropriate escalation of concerns. (**ongoing**)

PATIENT FLOW AND PATHWAYS
Every effort is made to encourage the use of existing patient flow pathways. This is managed through daily hospital management team meetings which includes all of the sites, across the Group and the CHO3 to maximise flow across the system. Operations team meetings at held at 9am and 4pm, chaired by the Head of Service for the site. The development of additional pathways will be looked at by the new Acute Care and Emergency Directorate. **Date for completion October 2023**

The GEM unit resources for the Rapid Response Frailty team have been recruited and complement the existing OPTIMEND Service (AHP) to ensure that older persons follow the appropriate pathway and are safely discharged home when appropriate from the ED. These services operate out of the dedicated GEM (Geriatric Elderly Medicine) area. The aim of the unit is for the patient group to be supported directly to the unit from Triage for ED and HSE team input in a dedicated over 75's unit. (**ongoing**)

In the Emergency Department current patient pathways include but are not limited to: GEM/Optimend, IcPOP (Older Persons Assessment Liaisons) and working with the Community Intervention teams in CHO3, Pathfinder, AMAU, ASAU pathway, ophthalmology, Stemi, DVT, First time seizure. (**ongoing**)

Promotion of pre-hospital alternative pathways to signpost adults to the MAU's on the model 2 sites via bed bureau. (**ongoing**)

Expanded the patient flow team to maximise the efficiencies across the patient flow process to ensure timely discharges and the maximum number of model 2 transfers. (**ongoing**)

Daily review of patients in ED with diagnostic requirements through Red2Green with early communication to pathology, radiology & cardiology to ensure prioritisation. (**ongoing**)

• Enhanced command and control arrangements:
-daily solution focused multi-agency hospital management team meetings led by Head of Operational Services and with EMT Oversight to ensure that all stakeholders are sighted on challenges and the group position.

-Formal 'battle rhythm' established with bed meetings three times a day to focus on site position, triangulate intelligence and mitigate surges.

-Improved use of data including use of HPVP to enhance planning and identify areas of focus including PET times. (**ongoing**)

• Increased AMU Slots in Model 2s at weekends as an Ed avoidance measure:
-Ennis, Nenagh & St Johns MAUs all working at weekends with a total of 32 slot available each day over the weekend (18 Ennis, 8 at St Johns and 6 at Nenagh). To increase to 12 on the Nenagh site in July. **(July 2023)**

• To continue to improve the discharge process: 35 % increase in discharges before 1600 (Feb to April 22 vs 23) enabled by:
-Implementation of Patient flow co-ordinators now fully established to 9 members working across the site to identify and resolve blockages to discharges

-New medical rota ensuring that there is a level spread of the medical take across the consultant body with an increase number of consultants participating in the on call rota. (**ongoing**)

• To continue to improve the number of DTOC's (median of 6 days for 2023 vs 9 days for2022 at 33%) Improvement enabled by:
-MDT approach to DTOCs and focus on 10-day length of stay which in turn reduces the 14 day AVLOS.

-Daily CCG and MDT rounds with key focus areas are planned discharges, outstanding diagnostics or consults, ward level trolley PETs, delayed transfers of Care, deteriorating patients, high risk patients and staffing levels. (**ongoing**)

ULHG are actively engaging with CHO3 to maximise capacity in Rehab, Long term Care/ Home Care Support across the region. **(ongoing)**

The internal escalation processes within the Emergency Department have been reviewed to ensure that delays are minimised for the patients availing of the services. Further improvements will be looked at to enhance operational efficiency in the Emergency Department and build on the gains in recent months. We will review our data to drive and sustain operational efficiencies. **(ongoing)**

Escalation plan has been reviewed and signed off by the Executive Management Team. This is closely monitored and executive and directive management teams are made aware of the UHL site position, level of escalation, 3 times a day. (**ongoing**) **INFRASTRUCTURE** To complete a review of ED infrastructure on the glass corridor to improve/support patient care and dignity and maximise the viable footprint to meet physical distancing requirements**. Date for Completion (September 2023)**
Timescale:

National Standard Judgments relating to the Emergency Department	Judgment
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high-quality, safe and reliable healthcare.	Partially compliant

Outline how you are going to improve compliance with this standard. If significant investment and time is required to come into full compliance with this standard this should be clearly outlined including:

(a) long-term plans to come into compliance with the standard
(b) details of interim actions and measures to mitigate risks associated with partial or non-compliance with standards.

HIQA Observations

Hospital management continue to experience challenges in filling nursing positions. At the time of this inspection, 25% (33.25 WTE) of the department's nursing staff positions were unfilled.
Nursing staff in the emergency department were supported by 29.26 WTE healthcare assistants, 33% of these positions were unfilled at the time of this inspection.

Interim Measures
The Nursing Department in UHL has a designated Assistant Director of Nursing for workforce planning **(ongoing)**

Proactive recruitment of Nurses and Healthcare Assistants both nationally and internationally will continue in 2023. Graduate recruitment campaigns are ongoing. A team from the Nursing and Midwifery Workforce Planning and Development Department completed a Face-to-Face Staff Nurse Interview Campaign in India in January 2023. 76 Staff Nurses were successfully panelled.
A number of other interview days have since been completed to meet the job order. 63% of Staff Nurses recruited from this campaign are being recruited specifically for specialist areas including Paediatrics, Renal, Critical Care, ED, Theatre and Cardiology. This Staff Nurse recruitment will enable the implementation of Safer Staffing in ED, UHL
UHL to complete the implementation of the Safe Staffing Framework in the Emergency Department **Date for Completion September 2023**

HCA Recruitment

Recruitment and Nursing/Midwifery Manpower have plan in place for HCA Campaign to run in Q2 2023 (HCA campaign is ran every quarter). ULHG will link with LCFE and Central College Limerick to attract students completing Level 6 Qualification. **Date for Completion October 2023**

HIQA observation

On the day of inspection, 80% (37) of the 46 WTE approved and funded NCHDs were filled. An additional 6 SHOs were due to commence in April 2023.

Interim Measure

A review of NCHD resources was completed and a submission for a further 10 SHO's and 10 Registrars was made nationally which was approved. 2 additional Consultants & 1 Reg. were also approved and are in post.

By July 2023 for the changeover of doctors, the current recruitment position indicates that there will be 21 additional NCHDs in post in the Emergency Department. **Date for Completion August 2023**

HIQA Observation

This uplift in medical staff has enabled some operational and clinical efficiencies to be achieved as evident in some improvements in the PETs. It is imperative that these gains are built on and further efficiencies are gained from the resulting redeployment of work practices in the department, increased availability of senior decision-makers at consultant level and revised escalation procedures.

Interim Measure

The internal escalation procedures within the ED have been revised and are monitored by the multidisciplinary team at the hospital management team meeting and at the safety Huddles within the department on a daily basis.

The additional NCHD's have allowed for an increase of 3 to 4 NCHD's on night duty and a greater spread of cover during the day including cover of the GEM unit. **(ongoing)**

The additional consultant has allowed for a consultant at triage to be present from 8am to 8pm. Mon- Friday. **(ongoing)**

There is a greater availability of consultants on the shop floor to enable earlier review of patients. **(ongoing)**

To monitor the efficiencies accrued from the additional resources through reviewing the ED KPI's at the unscheduled care meetings and at the monthly performance meeting for the newly formed Acute Care and Emergency Directorate: **Date for Completion September 2023**

Timescale:

National Standard Judgments relating to the Emergency Department	Judgment
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Non-compliant

Outline how you are going to improve compliance with this standard. If significant investment and time is required to come into full compliance with this standard this should be clearly outlined including:

(a) long-term plans to come into compliance with the standard
(b) details of interim actions and measures to mitigate risks associated with partial or non-compliance with standards.

HIQA Observations

1.6 The dignity, privacy and confidentiality of patients accommodated on trolleys was significantly compromised.

Persistent overcrowding in UHL's emergency department negatively impacted on any meaningful promotion of patients' human rights for the vast amount of patients in the department.

Interim Measures

- Comfort packs are provided to patients which include eye mask/sleep mask, foam ear plugs. Toiletry packs are also available. **(ongoing)**
- An emergency clothing stock has recently been introduced to the Emergency Department which provide clothing to patients, who find themselves in the department without essentials from home. **(ongoing)**
- Additional rounding is taking place by HCA's ensuring patient have pillows/blankets. **(ongoing)**
- The PALS Managers complete rounds within the department to support patients in the Department. They offer the comfort packs, pillows, clinical care updates if required. They offer to contact family/N.O.K. if a patient requires same. They offer support and give the contact details for the PALS service if required. They offer to address any immediate concerns the patient has and make every effort to resolve them quickly. **(ongoing)**
- The PALS team are currently in the process of recruiting PALS Volunteers for the Emergency Department to further support the patients. **Date for Completion September 2023**
- To promote the dignity, privacy and autonomy of patients, a cubicle is protected for use by the clinical teams when carrying out intimate clinical care within the zones in the ED. **(ongoing)**

- Portable screens are also available for use. **(ongoing)**
- Patients who are identified as End of Life Care are prioritised for a bed on the ward, if one is not available, the patient is accommodated in a single cubicle in the Clinical Decision Unit within the ED. **(ongoing)**
- Patients who present to the ED who are part of the Haematology/Onc service are prioritised for isolation if required and are transferred to the 2 assessment cubicles in Haematology/Onc Ward (6B) for work up if Resus is not required. **(ongoing)**
- To review the ED floor plan in line with the fire plan for the ED, so as to maximise the available space and promote physical distancing between trolleys. Process and SOP around management of these patients to be developed. **Date for Completion September 2023**
- Escalation plan to be further reviewed to reflect the current practice of flowing patients on trolleys to ward trolley spaces from ED in order to mitigate overcrowding in ED, rather than in stages as per the escalation plan. Date for Completion July 2023
- The continued monitoring of performance data at USC meetings. (AVLOS, DTOC's,
- PET times etc.) (ongoing)
- To further explore and develop a streamlined pathway for the >75's who attend ED which is currently in discussion. **Date for Completion October 2023**
- **Enhanced** Operational Grip
- -Daily solution focused multi-agency hospital management team meetings led by Head of Service for the site and with EMT Oversight to ensure that all stakeholders are sighted on challenges and group position. **(ongoing)**
- -A formal 'battle rhythm' approach is adopted to bed meetings, which are held three times a day to focus on site position, triangulate intelligence and address any surges. **(ongoing)**
- To continue to improve the discharge process: 35 % increase in discharges before 1600 (Feb to April 22 vs Feb to April 23) enabled by:
  -Implementation of Patient flow co-ordinators now fully established to 9 members working across the site to identify and resolve blockages to discharges. **(ongoing)**
  -New medical rota is in place with an increase number of consultants participating in the on call rota. This ensures that there is a level spread of the medical take across the wider consultant body
- To continue to improve the number of DTOC's (median of 6 days for 2023 vs 9 days for2022 at 33%)
- Improvement enabled by:
  -MDT approach to DTOCs and focus on 10-day length of stay which in turn reduces the 14 day AVLOS. **(ongoing)**
  -Daily CCG and MDT rounds with the focus on the following key areas: planned discharges, outstanding diagnostics or consults, level of ward trolley & the PETs for same, delayed transfers of Care, deteriorating patients, high risk patients and staffing levels. **(ongoing)**
- Long Stay Tuesday Forum established where patients with long lengths of stays are actively reviewed and any actions to progress to discharge identified and progressed. The team comprises the Head of Service, Allied Health professionals,

CHO3 representatives, nursing, Unscheduled Care Lead and Bed Management. **(ongoing)**

- Integrated DTOC meeting established, which meet weekly to ensure delayed transfers of care are minimised. **(ongoing)**

HIQA Observations

Documentation reviewed by inspectors would suggest that the number of referrals to these services could be better utilised. Community based services could be used more effectively for patients that meet the referral criteria and in doing so may, along with other measures, contribute to helping to avoid hospital admission, improve patient flow and inpatient bed availability at UHL.

Interim Measures

Further development of the Pathfinders service which commenced 24 Oct 2022

- To expand the referral pathways i.e. Mental Health services, MAUs, supporting discharges direct after ED assessment.
- To reduce age criteria from 65 to 60.
- To commence taking calls from Co. Clare (Solutions to low call volume discussed with NAS & agreed) **(ongoing)**

To review the current pathways in operation between the Acutes and CHO3 to ensure optimal use and hospital avoidance (i.e. CIT, IGPOP) **Date for Completion October 2023**

Long-term Measure

It has been identified that there is currently a shortfall of over 200 beds on the UHL site. Building works have commenced on the UHL site to construct an additional 96 bed block (44 replacement beds for the renovation of nightingale wards) single room inpatient facilities and will take approximately 18 months to complete. This will further increase the bed stock and ensure consistency in bed numbers in line with other Model 4 hospitals. **Date for Completion Q1 2025**

A further 96 bed block is at the early stages of planning and will provide additional single room inpatient facilities **Date for Completion 2027**

A steering group to be established to oversee the completion/ commissioning of the two 96 bed blocks and the phased renovation of the Nightingale wards. **Date for Completion July 2023**

National Standard Judgments relating to the Emergency Department	Judgment
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Partially compliant

Outline how you are going to improve compliance with this standard. If significant investment and time is required to come into full compliance with this standard this should be clearly outlined including:

(a) long-term plans to come into compliance with the standard
(b) details of interim actions and measures to mitigate risks associated with partial or non-compliance with standards.

HIQA Observations

At 11.00am on the day of inspection, the hospital was not compliant with any of the national key performance indicators for the emergency department set by the HSE.

- 61 (49%) attendees to the emergency department were in the department for more than six hours after registration — not in line with the national target which requires that 70% of attendees are admitted to a hospital bed or discharged within six hours of registration.
- 58 (47%) attendees to the emergency department were in the department for more than nine hours after registration — not in line with the national target of 85% of attendees being admitted to a hospital bed or discharged within nine hours of registration.

Interim Measures

With the increased NCHD & consultant staffing compliment in the Emergency Department, there is a commitment to work on reducing the % of attendees to the emergency department are in the department for more than six & 9 hours after registration by 5% within 6 months and 10% by year end. **Date for Completion December 2023**

HIQA Observations

- 24 (19%) attendees to the emergency department were in the department for more than 24 hours after registration — not compliant with the national target that 97% of patients are admitted to a hospital bed or discharged within 24 hours of registration.

Interim Measures

Continuous flow of trolleys to ward trolley spaces to reduce the overcrowding and enable the ED to work more efficiently. This is supported through the Daily solution focused multiagency hospital management team meetings led by Head of Service for the site. **(ongoing)**

The bed meetings, which are held three times a day to focus on status of the site, long PETS _ specific focus on long waits across the acute floor. **(ongoing)**
Establishment of the new directorate with responsibility for acute and emergency care only which will provide greater operational grip. **Date for Completion September 2023**

HIQA Observations

- 19% (23) of all attendees to the emergency department were aged 75 years and over. 16 (69%) of these patients were in the department for more than nine hours' after registration — not in line with the national target that 99% of patients aged 75 years and over are admitted to a hospital bed or discharged within nine hours of registration
- 9 (39%) attendees to the emergency department aged 75 years and over were in the department for more than 24 hours after registration — not in line with the national target that 99% of patients aged 75 years and over are admitted to a hospital bed or discharged within 24 hours of registration

Interim Measures

Improved pathways for frail elderly through greater use/ referral to the Geriatric Emergency Medicine Unit (GEM Unit): 45% increase in pts seen per week on previous quarter with 65% discharge rate (as at April 2023 @ 30.4 pts per week)

To fully implement the GEM unit service once building works have been completed, AHP staffing complement have been recruited and operational issues resolved. The additional Allied Health staff, will ensure timely assessment and early discharge. **Date for Completion September 2023**

To progress the following:

- AHP service 8 –8 service Mon –Fri & Sessional hours on Sat & Sun. (incl. Public Holidays)
- Set targets for throughput in unit 15 –20 pts/day and maintain d/c rates of 65%
- Implement outcome measures. (quality & satisfaction)
- Amend criteria to meet needs of additional patient cohorts in line with international evidence. **(ongoing)**

Additional WTE's and consultants at triage will also have a positive impact on waiting times

To progress the current discussions on an Emergency Medicine Programme for over 75's which focuses on frailty, identifying admission needs and prioritises this patient cohort for a bed when admission is required– Older Persons Pathway. **Date for Completion November 2023**

To continue to maximise the number of inter hospital transfers from the ED to create capacity. **(ongoing)**

HIQA Observation

Adequate physical distancing was not maintained between trolleys on the corridor in the emergency department and this posed a significant infection prevention and control risk for patients.

Interim Measure
To review the ED floor plan in line with the fire plan for the ED to maximise the use of available space to further promote adequate physical distancing between trolleys. Process and SOP around management of these patients in the locations identified to be developed. **Date for Completion September 2023)**

Continuous flow of trolleys to ward trolley spaces to reduce the overcrowding in the ED. **(ongoing)**

Robust governance and oversight of the ED numbers and escalation plan to ensure that there is full utilisation of the available bed capacity across the group through the daily multi-agency hospital management team meeting and the bed management meetings. **(ongoing)**

This is supported through the Daily solution focused multi-agency hospital management team meetings led by Head of Service for the site. **(ongoing)**

HIQA Observation
The Emergency Medicine Early Warning System (EMEWS) was not implemented in UHL.

Interim Measure
A clinical skills facilitator within the ED is rolling out the training on EMEWS and has commenced with 30% of the staff having completed same. It is planned to have completed the training of all staff in Ed by the end of August 2023. This will be in line with the completion of the Safer staffing recruitment for the ED. **Date for Completion September 2023**

HIQA Observation
Considering the association of prolonged waiting times in the department with increased morbidity and mortality, this remained a concern for HIQA. In the interim hospital management need to continue to ensure effective measures are implemented to protect the high numbers of patients receiving care in UHL's emergency department from potential and actual risk of harm arising from an overcrowded department.

Interim Measure
In Quarter one of this year we have implemented the Safety huddle in the ED. The aim of the Safety huddle is to promote behaviours that support a culture of safety including collective leadership, communication and multidisciplinary team working. The Safety huddle is held at the same time each day. Members of the MDT are encouraged to identify, share and action patient safety concerns and escalate accordingly. **(ongoing)**

Existing internal escalation processes within ED have been further reviewed, have been agreed and are being implemented. **(ongoing)**

The placement of an ED Consultant at triage Monday-Friday 8am-8pm. **(ongoing)**

The SAFER staffing levels for the ED were reviewed and approval has been received nationally to progress implementation. A number of these additional nursing resources have commenced with the remainder to be in place by the end of August 2023. **Date for Completion September 2023**

To review the ED floor plan in line with the fire plan for the ED to maximise the use of the available space and promote physical distancing between trolleys. Process and SOP around management of these patients to be developed. **Date for Completion September 2023**

To secure approval for additional core nursing and HCA staff (16 nurse &5 HCA's) & AHP's to care for the patients who are identified as requiring admission who are located within the emergency department following review of the ED floor plan. **Date for Completion December 2023**

To implement the Emergency Medicine Early Warning System (EMEWS) by September 2023. It is planned to have completed the training of all staff in ED by the end of August 2023. This will be in line with the completion of the Safer staffing recruitment for the ED and the changeover of doctors in July. **Date for Completion September 2023**

Establishment of the new directorate with responsibility for acute and emergency care only which will provide greater support and oversight for the ED **Date for Completion September 2023**

Governance of both risk and incident management is in place within the ED and in the Medicine Directorate. A Risk advisor is in place to support the Medicine Directorate and ED. Recommendations from incidents, complaints and reviews are being actively worked on once received to ensure that they are being implemented. **(ongoing)**

Additional equipment has been sought to support the ongoing care needs of patients in the ED e.g. Omnicell Drug dispensing system, ECG machines, pressure relieving mattresses for trolleys. **Date for Completion October 2023**

Timescale:

National Standard **Judgments relating to the wider hospital and inpatient clinical areas**	Judgment
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare.	Partially compliant

Outline how you are going to improve compliance with this standard. If significant investment and time is required to come into full compliance with this standard this should be clearly outlined including:

(a) long-term plans to come into compliance with the standard
(b) details of interim actions and measures to mitigate risks associated with partial or non-compliance with standards.

HIQA observations

Hospital management also experienced challenges in filling the following health and social care professional's positions in UHL:

- UHL had an approved funding for 75 WTE pharmacists, but 32% (24 WTE) of these positions were unfilled.
- UHL had a shortfall of 25% (11 WTE) between the approved and funded, and actual number of pharmacy technicians in position.
- 42% of the approved and funded physiotherapist's positions were unfilled.
- 24% of the approved and funded occupational therapist's positions were unfilled.
- 35% of the approved and funded medical social worker's positions were unfilled.
- 7.5% of the approved and funded dietician's positions were unfilled.
- 20% shortfall in the approved and actual number of clinical skills facilitators in position at UHL.

Hospital management need to ensure that there are sufficient staff available at the right time, with the right skills to deliver safe, high-quality care and that there are contingencies in place to ensure that the service can meet increase in demand for unscheduled and emergency care.

Interim measure
A Workforce Plan report has been prepared by ULHG to provide a high-level plan and outlines predicted recruitment activity and work force forecasting for UL Hospitals Group (ULHG).
Completed
There is considerable work underway to fill the vacant posts within the Health and Social care professionals. Significant number of posts have been approved and there are currently 16 recruitment campaigns arranged. (23 recruitment campaigns for allied health professionals have been advertised in Jan/February of this year. There should be a

significant uplift in numbers of Health and Social care professionals over the summer months with the new therapists graduating who have indicated a commitment to the group. It is anticipated that many of the AHP vacancies will be filled by way of International Recruitment with a Relocation Package to support same. **Date for Completion September 2023**

Under the HR Circular 006/2023, the HSE is offering Health & Social Care Professional 2023 graduates from all professions who are successful at interview a permanent contract. With this new change to the type of contract issued, early indications are that it is increasing the number of candidates applying for posts within the HSE.
Plans are in place to put a proposal to Pharmacy management with regard to running a rolling recruitment campaign. **Date for Completion December 2023**

HIQA Observation

In 2022, the hospitals staff absenteeism rate was 9.4% (excluding COVID-19), which was significantly higher that the HSE's target of 4% and the highest of all Model 4 hospitals that year. As the hospital remains an outlier when compared to their peer hospitals, it is suggested that hospital management further analyse and explore the reasons contributing to this rate.

Interim Response

Monitoring of Absenteeism rate.
Dedicated HR resources provide support to Directorate Management Teams in managing absenteeism. In particular, the identification of indicators involving cumulative number of days absent in a set period, number of episodes of absence in a set period, combination of days and spells and other pattern-related absences. This data assists in helping to identify those cases where the level of sickness absence has reached a point where some type of intervention is deemed necessary. This is monitored by each Directorate at their monthly performance meeting. **(ongoing)**

A Short Term Absence Management Checklist and Long Term Illness File Review Template has been developed in line with HSE Managing Attendance Policy to support Line Managers in a review of the Managing Attendance process and management of absenteeism. **(ongoing)**

This allows for continuing review and audit and is a supportive aide for managers. The premise is to continue to embed a culture of consistent attendance management. Key focus points also identified as part of a quality improvement plan included:

- Acknowledgement letters must be sent to all staff.
- SAP records are audited to reflect the absence periods.
- Return to Work meetings must be used in a constructive manner to manage absence.
- Supports offered such as the Employee Assistance Programme and Occupational Health must be detailed and documented.
- Continuing engagement, communication and support for those staff members that absent from work as a result of sick leave. **(ongoing)**

The bespoke ULHG HR Skills Programme which is facilitated several time a year for Line Managers provides education and support on the HR policies including a comprehensive focus on the Managing Attendance Policy and feedback from staff that have attended such sessions has been hugely positive. **(ongoing)**

Staff Engagement
The ULHG Staff Engagement Steering group was formed in 2021. Following on from the National HSE Staff Survey, a key priority was to increase the Staff Engagement levels for ULHG, take on board and deliver on feedback from our staff body.
Under the overarching Steering Group sits a local working group in each of the hospital. All cohorts of staff are represented and the respective local working groups provide updates to the Steering Group on a monthly basis. **(ongoing)**

Staff Health & Wellbeing
As outlined, staff engagement continues to be of paramount importance and following this feedback, some key and very well received initiatives for our staff in Q1 2023 included a half day training programme on Suicide Alertness. Recognising the importance of Mental Health, further training courses are planned to take place. **(ongoing)**

Learning & Development Opportunities
The Learning and Development Unit (LDU) in the ULHG have made great strides in the development of an online learning management system ULHG. Achieve. At ULHG we have tailored our approach to fit organisational needs by establishing career development pathways across administrative grades. By doing so we can provide not only interesting and engaging programmes but also ones that are valuable as they relate to employee specific job roles. The platform contains locally devised programmes and content for employees of UL Hospitals Group. **(ongoing)**

Exit Interviews
The exit interview process has been developed in line with the UL Hospitals Strategic plan 20182022 to "source, capture and respond to the views, opinions and feedback of staff". All staff who leave ULHG are issued an Exit Interview Questionnaire. The rationale for this process is to provide an opportunity for staff exiting of our Hospital Group with to provide feedback on their experience. Exit Interview Compliance per Directorate are now included in Directorate Performance Packs. This will help managers focus on improvements as identified in report for reasons for leaving per Directorate. **(ongoing)**

Covid Impacts on staff i.e. burnout
ULHG proactively promoted self-care, encouraged adequate sleep while off-duty, healthy eating and keeping hydrated with health promotions and initiatives through our Health & Wellbeing Department being offered to staff. ULHG promoted staff supports including local EAP HSE in-house services and external service providers Staff Care Line; a 24/7 confidential free service with direct access to qualified counsellors. **(ongoing)**

HIQA Observation

Staff training records from the inpatient clinical areas visited showed that the uptake of essential and mandatory training in basic life support, early warning systems, hand hygiene and sepsis management was sub-optimal and should be an area of focused improvement following this inspection.

It is also essential that hospital management ensure that all clinical staff have undertaken mandatory and essential training appropriate to their scope of practice and at the required frequency, in line with national standards.

Interim Measures

Feedback: The Resus Officers work closely with the Clinical Skills Facilitators for these areas to arrange optimal attendance at Basic Life Support Training. Since January of 2023, 6 additional BLS classes have been arranged for Medicine and ED.
We will continue to work with the CSFs to identify numbers requiring BLS training in the areas outlined. **(ongoing)**

Action: Additional courses being arranged/provided. To trial the booking of BLS classes through HSELand to offer staff more flexibility with booking onto courses run by our Dept.
Date for Completion August 2023

Feedback
Trauma
Current % as off 18/05/2023

MODULE	%
Hand Hygiene	81%
Sepsis	85%
INEWS	85%
CPR	100%

Training Modules of the Month have commenced in Orthopaedics and a QIP is in place. INEWS has been included in the September modules, Hand Hygiene & Sepsis have been included in March Modules. There has been an increase in the 3 remaining areas.

Action

To further increase % of compliance staff to be contacted directly that their training is out of date and to send me certs by COB Thursday May 25th for Hand Hygiene & Sepsis.

Training on INEWS has been arranged for week commencing the 23rd of May. 4 Face to Face sessions with contact with the CNMs to ensure staff are released.

3A

Mandatory training log currently shows compliance for BLS, EWS, HH and sepsis which are all above 80%.

Module	% Trained Nurses	% Trained HCAs
Hand Hygiene	96%	83%
Sepsis	92%	N/A
INEWS	80%	N/A
BLS	88%	100%

Ward 3A Mandatory Training QIP is in place since January 2023 which includes a 'Mandatory Module of the Month' schedule.

3D

Current figures

Module	%
Hand Hygiene	76
Sepsis	69
INEWS	72
BLS	82.5

QIP developed to improve current training levels for mandatory training.
4 staff nurses are booked in for BLS in June and 1 HCA. That will increase their numbers to >90% for staff nurses and 100% for HCAs.
Sepsis: Module of the month for Sepsis is in June so that will ensure numbers will be >90%. INEWS: Module of the month for INEWS has been moved to July to ensure compliance rate of >90%.
Hand hygiene: Module of the month for June to ensure compliance at 100%.
Date for Completion August 2023

Hand Hygiene Train-The-Trainer Programme starting in June 2023- this will afford all ward areas/units the chance to have staff trained on how to deliver hand hygiene training to peers within their area of work and is expected to increase compliance rates across the group as the programme embeds within the group. **Date for Completion June 2023**

Timescale:

National Standard **Judgments relating to the wider hospital and inpatient clinical areas**	Judgment
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Non-compliant

Outline how you are going to improve compliance with this standard. If significant investment and time is required to come into full compliance with this standard this should be clearly outlined including:

(a) long-term plans to come into compliance with the standard
(b) details of interim actions and measures to mitigate risks associated with partial or non-compliance with standards.

HIQA Observation

There was evidence of general wear and tear of woodwork and floor surfaces, with paintwork and wood finishes chipped, which did not facilitate effective cleaning and posed an infection prevention and control risk.

Storage was an issue in all the clinical areas visited during inspection.

Interim Measures

Trauma ward
AMRIC funding has been secured to the value of 195K to address the following issues on the trauma ward.

- Storage requirements (removing timber presses and installing Kan Ban)
- To create a new linen store
- Plans for the Clean utility & drug prep rooms
- Remove and install compliant clinical wash hand basins
- Remove Shower room.
- Plan to move cleaners store to drug room & also move clinical room.

These works have gone out to tender and are due for completion before the end of November 2023. **Date for Completion Nov. 2023**

3A &3D

Both ward 3A & 3D have previously identified maintenance work that has been logged with the maintenance department for completion. The maintenance department have confirmed that these works are scheduled to be completed in the coming months. These works include painting, replacement of some damaged surfaces, storage and flooring. **Date for Completion Oct. 2023**

HIQA Observation

Adequate physical distancing was a challenge in the large 'nightingale' multi-occupancy rooms.

The number of isolation rooms with adequate en-suite bathroom facilities was insufficient for a Model 4 hospital.

Long-term Measure

Building works have commenced on the UHL site to construct an additional 96 bed block (44 replacement beds for the renovation of nightingale wards). The new block will be single en-suite inpatient rooms and will take approximately 18 months to complete. This will add a further 52 single rooms to the UHL site. **Date for Completion Q1 2025.**

A further 96 bed block is at the early stages of planning and will provide will provide 96 single en-suite inpatient rooms due for completion in 2025. **Date for Completion 2027**

Timescale:

National Standard **Judgments relating to the wider hospital and inpatient clinical areas**	Judgment
Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Partially compliant

Outline how you are going to improve compliance with this standard. If significant investment and time is required to come into full compliance with this standard this should be clearly outlined including:

(a) long-term plans to come into compliance with the standard
(b) details of interim actions and measures to mitigate risks associated with partial or non-compliance with standards.

HIQA Observation

Hospital-associated Clostridioides difficile ranged from 1.20 to 7.30 new cases per month, with UHL above the HSE's target (less than 2 per 10,000 bed days) for eight of the 12 months of 2022.

It was noted by inspectors that the difficulties that hospital management at UHL have had in managing CPE and Clostridioides difficile infection outbreaks. In the context of UHL's underlying infrastructure and high occupancy rates, there is a need to further enhance infection prevention and control systems and processes at the hospital.

Interim Measures

- To enhance training practice and monitoring by providing scheduled on-ward training sessions to enable staff get relevant training on IPC practice whilst at the point-of-care. This aims to increase attendances at training sessions.
- IPC to conduct independent environmental audits in areas of concern- these IPC environment audits will be independent of the area's own environmental auditing schedule.
- Areas of significant infrastructural concern are planned to be addressed under AMRIC's Minor Capital Funding Programme 2023. **Date for Completion Nov. 2023**

HIQA Observation
Hand hygiene audit results for the emergency department was 87%.
Interim Measures

- A re-audit of Hand Hygiene practice carried out in the ED on 02.03.23, post the 87% result, showed a 6% increase in compliance, 93%, meeting the compliance target. **(ongoing)**

- Hand Hygiene Train-The-Trainer Programme starting in June 2023- this will afford all ward areas/units the chance to have staff trained on how to deliver hand hygiene training to peers within their area of work and is expected to increase compliance rates across the group as the programme embeds within the group. **Date for Completion June 2023**

HIQA Observation

Inspectors noted that only 70% of patients eligible for CPE screening were actually screened for the infection in 2022.

Interim Measures

- To address poor CPE screening compliance, The IPC Department has dedicated an IPC administrative team to reviewing all admitted patients, identifying if screening criteria are met, compiling a list of identified patients and delivering this data to individual unit managers. This initiative aims to increase CPE screening compliance across all areas of ULHG. **(ongoing)**
- The IPC Department has trialled and aims to incorporate a newly-designed MDRO identification tool into the nursing admission document. This tool aims to enhance the structure around rapid identification of the need for screening for MDRO's, including CPE, with the final aim of increasing compliance with screening.

HIQA Observation

There was limited evidence in the documentation reviewed by inspectors that compliance with national guidance on INEWS and sepsis management was regularly audited at UHL. This is something easily remedied following this inspection.

Interim Measures

Sepsis: UHL has carried out a Sepsis audit for Q3 2022. A QIP was put in place which included twice weekly morning and afternoon education sessions in the ED department on the recognition and management of sepsis using the sepsis 6 bundle of care.
INEWS: INEWS Escalation and Response audits have commenced in UL since January 2023 with 5 charts per quarter audited across UL. **(ongoing)**
To progress Sepsis and INEWS audits to all the wards. A deteriorating patient sub-group is being set up to oversee/implement the audit schedule for the year for Sepsis and INEWS. This group will have its 1st meeting Tuesday June 13th 2023. **Date for completion August 2023.**

Timescale:

Service Provider Use	
Service Provider	HSE, UL Hospitals Group
CEO/General Manager/Master Signature	
Date	**25.05.2023**

HIQA Official Use	
Date Reviewed	26.05.2023
Authorised Person(s)	**Denise Lawler**
Signature